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Official Report of Debates (Hansard)

Wednesday 23 November 2016

Journal des débats (Hansard)

Mercredi 23 novembre 2016

Standing Committee on the Legislative Assembly

Patients First Act, 2016

Comité permanent de l'Assemblée législative

Loi de 2016 donnant la priorité aux patients

Chair: Monte McNaughton
Clerk: Trevor Day

Président : Monte McNaughton
Greffier : Trevor Day

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Wednesday 23 November 2016

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Wednesday 23 November 2016

Mercredi 23 novembre 2016

The committee met at 1301 in committee room 1.

PATIENTS FIRST ACT, 2016
LOI DE 2016 DONNANT LA PRIORITÉ AUX PATIENTS

Consideration of the following bill:

Bill 41, An Act to amend various Acts in the interests of patient-centred care / Projet de loi 41, Loi modifiant diverses lois dans l'intérêt des soins axés sur les patients.

The Chair (Mr. Monte McNaughton): Good afternoon, everyone. Welcome to the Standing Committee on the Legislative Assembly. We're here for public hearings on Bill 41, An Act to amend various Acts in the interests of patient-centred care.

DR. SOHAIL GANDHI

The Chair (Mr. Monte McNaughton): I believe our first presenter is here, Sohail Gandhi. Good afternoon.

Dr. Sohail Gandhi: Where would you like me to sit?

The Chair (Mr. Monte McNaughton): Right where the light is there.

You have nine minutes for your presentation, followed by two minutes of questioning. The questions will begin from the official opposition. If you would just state your name for Hansard, and then begin.

Dr. Sohail Gandhi: I'm Dr. Sohail Gandhi, and I'm a family physician from Stayner, Ontario, in the Georgian Triangle region. For the past 24 years, it has been my pleasure to provide front-line primary care to 1,700 of my patients in south Georgian Bay.

I know that this committee has heard from a number of other physicians and physician groups about their concerns about the Patients First Act. I, however, would like to take a slightly different tack and talk about how, in south Georgian Bay, we have had a long history of a mutually co-operative, respectful relationship with the Ministry of Health and government agencies, how that's benefited the residents of south Georgian Bay and, finally, getting to how that relationship is going to be threatened by the Patients First Act.

To understand our relationship, we have to go back to 2001, when family medicine was in crisis. Over three million patients were without a family physician in Ontario and only 15% of medical school graduates went into family medicine. In south Georgian Bay, front-line physicians like myself decided to address this crisis by rolling up our sleeves and working with the Ministry of Health through what was called the Ontario Family Health Network and begin the process of implementing primary care reform in south Georgian Bay.

What did this mean for the Ministry of Health and what did this mean for the patients? What it meant was that the physicians for the first time agreed to a governance agreement that governed their own code of conduct. It meant that for the first time, we had a stabilized after-hours clinic that provided seven days of care to the patients of south Georgian Bay, off-loading working from the emergency department. It meant that the physicians voluntarily agreed to switch to a capitation-based funding model that provided a stable and predictable budget for the Ministry of Health. And it meant in our neck of the woods that we stabilized the medical manpower situation at the Collingwood General and Marine Hospital that had been in crisis as a result of the changes of the 1990s.

In 2007, as part of this evolution of primary care reform, I was personally honoured to be selected by my colleagues to be the founding chair of the Georgian Bay Family Health Team. Working with other strong family physician leaders who provided front-line care, we were able to implement, working co-operatively and respectfully with the ministry, a number of significant programs in the area that have significantly benefited our patients. For example, we implemented a diabetic teaching program that reduced the rate of hospital readmissions by over 30%. We implemented a pediatric and adolescent mental health service, an area that in our neck of the woods had been described as a barren wasteland, and so provided care to some very, very disadvantaged youth. We implemented a health care provider portal that allowed for a reduction in over 50% of admissions to hospital from nursing homes. And we've implemented much, much more because we had strong, front-line family physicians who were working with the government, who knew the lay of the land and did not have to hire expensive consultants to do needs assessments because we already knew what our community needed. In fact, the program was so successful that even though our business plan said, "You're going to look after 25,000 patients," we now look after 60,000 patients.

To understand how different that is from Patients First and the process behind Patients First, we have to look at

the genesis of the Patients First Act and how it came into being. The Minister of Health commissioned something called the Price report, a report on population-based geographic funding, which is the genesis and the seed for the Patients First Act. This Price report was presented to the Minister of Health in May 2015 and was immediately embargoed by the Minister of Health and made confidential. It was not released to front-line family physicians, and their co-operation was not asked.

What was unbeknownst to us was that the Minister of Health gave the Price report to the administration of all of the LHINs in Ontario and told the LHINs to develop an implementation plan for the Price report, which is what became Patients First. I only found out about it when, at a meeting of the primary care leads that had been previously scheduled on September 30, 2015—so four months later—we were told that 45 minutes was going to be added to the minutes to discuss ways to implement the findings in the Price report. Unbeknownst to us at the time, the committee report from the LHIN, the implementation plan, was to be submitted to the Minister of Health eight days later, on October 8, 2015.

When I found out about this, on December 3, 2015, I emailed our LHIN and I asked for a copy of the implementation plan that our LHIN had submitted. I was rejected because once again the Minister of Health had embargoed the report and made it confidential.

On December 17, 2015, the Minister of Health finally released the Price report to the general public, and in his statements when he released the report, he stated that he was looking forward to hearing from front-line health care workers on ways to develop plans to implement his report. He failed to mention in his press report that he already had an implementation plan, that the LHINs had given him that implementation plan two months previously.

On January 7, 2016, the implementation plan by the LHIN was finally released, and the only front-line input that was given to the implementation planning—our LHIN—was on February 1, 2016, when 70 physicians were invited to a meeting to discuss the implementation plan. Six showed up, three with the express reason of showing up to tell the LHINs that, "Look, until you can repair the relationships between family physicians and the Minister of Health, you shouldn't go forward." Despite that, the Minister of Health continued to go forward and has now brought in the Patients First Act. This is why Dr. David Schieck, who's the chairman of the section of general and family practice of the Ontario Medical Association, referred to this consultation last week in a press release as a pretend consultation.

If we look at the Patients First Act further, we can see that it moves further away from what has been historically a successful, collaborative and mutually respectful relationship with physicians and the Ministry of Health. If we look just at the explanatory note at the beginning of the Patients First Act, there are four references in the explanatory note alone to "by order of the Lieutenant Governor in Council." We all know that that just means whatever the Minister of Health says.

There are five separate references in the explanatory note alone where it says clearly that the Minister of Health is given power to direct certain aspects of care.

If we look at the entire bill, there are numerous other examples of "Lieutenant Governor in Council" and the minister giving himself power, including the ability to direct program planning, the ability to determine practice patterns, the ability to determine clinical guidelines and the ability, under section 12.1(4)(a), to look specifically at individual patient records, all of which he can do without consultation or collaboration with any front-line workers. If you look at the history, this is why collaborating and working co-operatively with physicians works, as it has in our neck of the woods, and this is why Bill 41, the Patients First Act, is doomed to failure.

The Chair (Mr. Monte McNaughton): Great. Thank you very much, Doctor.

We'll move to Mr. Yurek from the official opposition.

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Mr. Jeff Yurek: Thanks for coming in today and sharing your thoughts. I find it unbelievable to hear that a group of doctors in south Georgian Bay has created what we all want the health care system to be: patient-centred, cost-effective, access to services when you need them. It seems that you've accomplished that. It's shocking that nobody in the Ministry of Health called you up and said, "How can we replicate this across the province?" Instead, they've come out with Bill 41, which, as you said, you weren't really consulted on.

Is it possible, if you have the same type of doctors throughout the province, to replicate the model in Ontario?

Dr. Sohail Gandhi: We have the same type of doctors across the province, first of all. Certainly, in my LHIN, there are five geographic what are now referred to as sub-LHINs in our area. I can tell you for a fact that, in each of the five sub-LHINs, there are a number of physicians who are yearning for a mutually respectful, collaborative relationship with the government, so that this type of model can be implemented.

When I was the Health Links lead physician, I reported on our model on numerous occasions to various government agencies, including presenting on our model to Cynthia Morton, who is the chair of eHealth Ontario.

So it's not for lack of advertising, shall we say, that the benefits of our model have not been presented or have not been heard of.

Mr. Jeff Yurek: Do you find that Bill 41, as it stands, will achieve its stated goal: putting patients first?

Dr. Sohail Gandhi: The success of our model was because family physicians' opinions were sought and their opinions were valued. All of their recommendations were not accepted. That's a bit ridiculous, and we all know that. It has to be a mutual give-and-take in a collaborative, respectful manner—

The Chair (Mr. Monte McNaughton): Thank you, Doctor. Sorry, we have to move to the third party.

Madame Gélinas.

M^me^ France Gélinas: Actually, I will continue on your same train of thought. Patients First is supposed to be the fix to our broken home care system. Can you see anything in Bill 41 that will help your patients get better home care?

Dr. Sohail Gandhi: No.

M^me^ France Gélinas: None whatsoever?

Dr. Sohail Gandhi: No. The concept of Bill 41 is to try to move the CCACs to the LHINs. Ted Ball, who runs Quantum Transformation Technologies, did an independent survey of health care leaders. I think that only about 25% of health care leaders felt that the LHINs were capable of taking that responsibility on. So I can't see this being successful at all.

M^me^ France Gélinas: So not only will it further deteriorate the relationship between the government and the physicians who work in this province, it will not achieve its goal of improving the home care services that your patients depend on. What do you figure it will do?

Dr. Sohail Gandhi: I don't know. I really have no idea how this bill came into being in the current political environment. That's beyond me.

M^me^ France Gélinas: It's a question that a lot of us wonder about as well.

I thank you for your time.

The Chair (Mr. Monte McNaughton): We'll move to the government. Ms. Wong.

Ms. Soo Wong: Thank you, Doctor, for being here. As you know, in the Patients First legislation, the government is committed to connecting the primary care providers to everyone who wants one—because not everybody wants a primary health care provider.

The data showed us that 57% of Ontarians cannot see their primary care provider on the same day or the next day when they're sick, and 52% find it difficult to access care in the evenings and on weekends.

My question to you, through the Chair, is, how do you work with us—in terms of your colleagues—collaboratively to improve that access to primary care services?

Dr. Sohail Gandhi: I think I answered that, Mr. Chair, in my presentation. I appreciate the provincial data, and I appreciate the concern about provincial data from a provincial government. In my neck of the woods, those numbers are not what you'd see, because of the ongoing mutually collaborative relationship. We work together. We developed the after-hours clinic to stabilize patient care. Most of us have moved to advanced access as part of our governance agreement.

So we've done all of that work, and quite frankly, I think our model should be a model that should be promoted throughout the province to address your concerns.

Ms. Soo Wong: Can you just share with us what your LHIN is?

Dr. Sohail Gandhi: North Simcoe Muskoka.

Ms. Soo Wong: How much time do I have, Mr. Chair?

The Chair (Mr. Monte McNaughton): Thirty seconds.

Ms. Soo Wong: Okay. Well, anyway, thank you for your good work. We really appreciate you being here today and taking time from your busy day to be here.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation.

Dr. Sohail Gandhi: Thank you.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Monte McNaughton): I'm going to now call upon the Ontario Hospital Association. Good afternoon. If you would both state your name for Hansard, and you'll have nine minutes for your presentation.

Mr. Anthony Dale: My name is Anthony Dale, and I'm president and CEO of the OHA.

Mr. Pierre Noel: I'm Pierre Noel. I'm the president and CEO of the Pembroke Regional Hospital, and a board member of the Ontario Hospital Association.

Mr. Anthony Dale: Thank you for allowing us to be here today. The OHA represents the province's 147 hospitals, and our mission is to create a high-performing health care system to better serve the needs of patients and clients. Again, thank you for the opportunity to provide comments on this bill, Bill 41, or the Patients First Act.

Ontario hospitals are willing and eager to work closely with their health system partners to support the implementation of Bill 41. In our view, the ongoing collaboration of all health system partners is needed to support a successful transition. Bill 41 represents the most significant restructuring of the health system in over a decade, and provides an opportunity to welcome and establish new approaches to patient-centred care.

Before I provide comments on the bill on behalf of our sector, I'd like to take a moment to thank the government for acknowledging many of the concerns already raised by the OHA and its member hospitals. Amendments were introduced through Bill 41 that better recognize the roles and responsibilities of hospital boards, which support the critical role that hospitals play in the health care system. The OHA and its members truly appreciate these changes. The amendments made will allow boards to continue to elevate hospital performance and will help to ensure stability during this critical period of health system transformation.

In the spirit of supporting this transformation in the year ahead, the OHA and its members have identified three key ways to lend their support. These include ensuring stability throughout the transition, continuing to enhance LHIN capacity and governance, and adopting and expanding innovative models of care.

As you know, all segments of the health system are interdependent. For example, a strong and reliable home and community care sector is needed to ensure that patients can move easily from the hospital back to the home. The government, LHINs and every health service provider have a vested interest in maintaining continuity and preventing gaps in services.

As such, clear and consistent communication to all health system partners is an essential change manage-

ment strategy in the time ahead as home care services move from CCACs to LHINs. Further details regarding the transfer process and timing of key implementation dates would be extremely beneficial for hospitals in setting expectations and planning for potential impacts on patient care.

In addition to keeping everyone informed, it will also be important to involve all stakeholders in the implementation process. Hospitals have long-standing relationships with primary care physicians, community agencies, municipalities and other hospitals, and are willing to share this expertise and knowledge.

One particular way that hospitals could provide support is through physician engagement. Hospitals are uniquely positioned to strengthen relationships between hospital-based specialists, family physicians and other primary care practitioners. This is especially true in northern and remote communities, where hospitals and primary care are tightly linked. It is important to leverage the experience of hospitals in building and maintaining these relationships.

Next, the OHA believes that continuing to enhance LHIN capacity and governance will help to strengthen the transition and implementation process. To cover that, I'll turn that over to Pierre.

Mr. Pierre Noel: Great. Thank you, Anthony.

Many roles of health service providers, LHINs, hospitals and the ministry overlap in the health care system, and this can create uncertainty about who should take the lead. Clarifying the roles and responsibilities of each would enhance the functioning of all health systems partners and, by extension, help facilitate and improve system transformation.

Additionally, Bill 41 greatly expands the roles and responsibilities of LHINs, as you know. The LHINs will require new skills and expertise to fulfill their new mandate as system managers and service providers. To ensure that the governance of LHINs is based on leading practice, board members should be representative of the communities they serve, and the boards should employ principles of good governance with respect to size, composition, skills and length of term.

Finally, Bill 41 represents the potential for revolutionary change in the way that the health care system is organized. Bill 41 is an opportunity to establish new approaches to patient-centred care. In particular, Ontario hospitals support creating models of care that are flexible in nature and that meet the needs of the communities they serve.

Due consideration should be given to having health service providers deliver home and community care where it best serves the patients. In this regard, two innovative models of care, bundled payments and health hubs, have been successful at improving integration and patient outcomes.

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In the bundled care model, a single payment is provided to a single fund-holder organization which supports services from multiple providers across multiple settings. When a physician aligns with non-physician partners, including hospitals and community services, it often results in lower costs and improved coordination.

In the health hub model, a single funding envelope and single governance structure is used. All components of the health care system are formally linked to create an end-to-end integration. In smaller communities where critical mass is an issue, proactively sharing staff and resources is very effective in maximizing available resources and strengthening the system.

The OHA believes that existing bundled care prototypes and health hub pilot sites should be leveraged to inform new initiatives.

In closing, on behalf of the OHA and our members, I'd like to thank you for the opportunity to present today. Anthony and I are certainly here to answer any questions you might have of us.

The Chair (Mr. Monte McNaughton): Excellent. Thank you very much. We'll begin with Madame Gélinas.

M^me^ France Gélinas: Je commence en disant bonjour, monsieur Noel. Ça fait longtemps que je ne vous ai pas vu.

M. Pierre Noel: Oui, ça fait longtemps.

M^me^ France Gélinas: Ça me fait plaisir de vous revoir.

My first question is, in the previous iteration of the bill, the LHINs could appoint supervisors for your hospitals. We were able to fix that. Are you happy with the fix that was brought into Bill 41?

Mr. Anthony Dale: In general, the government has responded to all of the major OHA recommendations that were focused around restoring the balance that has always existed between the role of hospital boards and then the funder—in this case, the LHINs.

M^me^ France Gélinas: So you're satisfied with the changes?

Mr. Anthony Dale: In general, yes.

M^me^ France Gélinas: In general? Okay.

When we talk about how the boards of the LHINs needed—and you go quite into some detail as to using good governance and representing their community. The changes are scheduled to happen on April 1. Knowing what you know of the different LHINs, are they up to par now?

Mr. Pierre Noel: Well, I don't know that every LHIN is exactly on the same footing, but the OHA's advice to government was to look at governance best practices. We have a Governance Centre of Excellence at the OHA where we promote these practices and where we look for people from the community to be part of the governance structure of the entities that provide care and oversight. There are good governance practices around length of terms and turnover etc.

The order-in-council appointment process is something that we advised against because it—

M^me^ France Gélinas: Would you support an elected board at the LHINs?

Mr. Pierre Noel: Yes—

The Chair (Mr. Monte McNaughton): Sorry. We have to move to the government now, and Mr. Bradley.

Mr. James J. Bradley: Thank you very much for your team's continued engagement. We appreciate the positive approach you have taken and the fact that you have acknowledged publicly that there has been considerable consultation that has taken place. That's very much appreciated, and your input has been valuable in terms of having the government modify its position on certain aspects of the bill.

I'd be interested in having you elaborate on the opportunities that hospitals have to collaborate and, in fact, to strengthen their linkages with the LHINs, the primary care deliverers and the home care sectors to improve transitions to care. I'd be really interested in what your observations are, because you've looked into this very deeply over the past several months, and indeed before that.

Mr. Anthony Dale: Well, thank you for that question. In general, we feel that the hospital sector, because of its overall size—I mean, it's a $20-billion industry and it has quite a bit of capacity within it in areas that could be useful at the sub-LHIN level in creating new models of care. That could be decision-support activity, that could be the use of health data and analytics, it could be governance expertise or different managerial competencies.

At the same time, we really appreciate that the purpose of the bill is to build capacity in the primary care and home and community care sectors. That's the overarching ambition of the bill and we absolutely accept that. But we do think that when key partners request the participation of hospitals, which we hope is often, they will be seen as very strong potential collaborators in building the new model of care in the first place, which is of course the very purpose of the bill.

Perhaps I'll just ask Pierre to comment again on some of the new models that we're also quite excited about, whether that's bundled payment or health hubs, because those are core ingredients into the future design of the health care system.

The Chair (Mr. Monte McNaughton): With that, I'm sorry, we have to move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. My first question—you can touch on it, too. We've had several groups in over the past few days discussing the fact that they think the LHIN should have the power to tell hospitals they must provide medically assisted dying. What are your thoughts, as an organization representating all the hospitals, on giving the LHIN that power to do so?

Mr. Anthony Dale: I appreciate that question. It's an extremely sensitive and timely one and also deals with one of the most complex questions our health care system has ever dealt with.

The bill does contain a provision which ensures that denominational hospitals cannot be directed to do anything that's against their mission. I know not everyone will agree with that, but the truth of the matter is also that medically assisted dying is one of a range of many health services that are delivered in hospitals and other organizations across this province, and many of the most complex kinds of care are not delivered in every single hospital. In fact, they are often concentrated in hospitals with special expertise and capacity to do just that.

We haven't seen the government's legislation on medically assisted dying yet. We've had briefings on it, but I imagine in the very near future we'll see that legislation in this House. We'll absolutely be contributing to that discussion because all across this province, hospitals are actively preparing to meet the needs of patients. It's just that there is some complexity to this, and we were saying on the way up here that now, above all other times on this subject matter, it's important that there be a lot of listening and a lot of talking, because again, it is one of the most complex subjects our health system will ever have dealt with.

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time we have. Thanks for your presentation.

Mr. Pierre Noel: Thank you.

Mr. Anthony Dale: Thanks.

OFFICE OF THE FRENCH LANGUAGE SERVICES COMMISSIONER

COMMISSARIAT AUX SERVICES EN FRANÇAIS

The Chair (Mr. Monte McNaughton): We now call upon the commissioner of French-language services. Bonjour. Bienvenue.

You'll have nine minutes for your presentation, followed by two minutes of questioning from each party. If you would both state your names for Hansard and begin.

M. François Boileau: Well, first off, thank you very much, Mr. Chair, for allowing us the time to present.

Tout d'abord, je voudrais vous remercier de nous avoir permis de comparaître aujourd'hui afin de vous présenter les éléments clés du mémoire déposé par le Commissariat aux services en français.

La santé est un dossier prioritaire du commissariat depuis les tout débuts de mon mandat. En effet, de nombreuses études prouvent que la santé d'une communauté passe par la santé de ses membres.

When we fall ill, we lose our faculties and we are unable to function normally. We are vulnerable. Whether illness has struck a loved one or us personally, we have all been in this situation.

When we find ourselves in this situation, we look for ways to make ourselves feel better. We look for guidance and, in most cases, we have to call on someone in the health care field.

With this in mind, I'd like to tell you a story, a story about the reality francophone patients live with. Afterwards, I will propose two additions to Bill 41 that would remedy the unacceptable state of the availability and quality of French-language health services.

My first story is about Tom, who was only four years old when he underwent surgery. At the time, his mother made sure that the entire medical team knew that her son spoke French and might speak to them in French, even though he understood a bit of English. She also translated everything that the doctors said about the surgery into French for her son. She reassured him and told him what was going to happen.

When the surgery was over, Tom opened his eyes in the recovery room and quite naturally asked in French for his mother, who was in the waiting room. The nurse did not understand French and thought that he was becoming agitated, but was unable to understand what he was saying. Even though he was perfectly fine, she administered a sedative and Tom went back to sleep.

Time passed and Tom's mother became worried. When she asked the nurse what was happening, she was told that her son had been babbling incoherently and that they had concluded that he was showing signs of post-operative confusion.

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Tom's mother was angry. Her son was not incoherent when he woke up; he was speaking French. In spite of her insistence before the surgery, no one recognized that Tom was speaking French and was simply asking for his mother. Surgery that took less than an hour turned into a day-long ordeal for this four-year-old.

Now, some years later, Tom's parents reiterate that francophone patients must remain vigilant where their health needs and health care are concerned. This experience undermined their confidence in the health care system and strengthened their resolve to ask for French services in the future.

Another story is about a French-speaking man who was prescribed a nitro pump by his English-speaking cardiologist. When the patient returned to the clinic for a follow-up visit, the nurse practitioner realized that because of his limited ability to understand and speak English, he had not grasped how to use the pump. He thought that he had been given a ventilator and was using it only when he really needed to. If he had not returned as quickly as he did to the French health care centre for his follow-up appointment, there could have been very serious consequences for his health.

These stories reflect the consequences that inaction has for francophones. If nothing is done to improve access to French-language health services, it is francophone citizens who are affected. Such inaction has after-effects that could be serious or even fatal. It also leads to costly repercussions for the patient and the Ministry of Health and Long-Term Care.

Dans le cadre de mon mandat, nous recevons de nombreuses plaintes de ce genre. Elles nous renseignent et nous inspirent à proposer des changements qui répondent aux besoins des francophones. Elles me permettent également de déclencher des enquêtes spéciales.

Ce fut le cas en 2009, avec la publication du Rapport spécial sur la planification des services de santé en français en Ontario. Comme vous le savez sûrement, ceci a permis la création des six entités de planification des soins de santé l'année suivante, le sujet de ma première proposition de modification au projet de loi.

The entities' role is to promote greater access to health services in French. They also work to improve the quality of services, and they make sure that the services address the specific needs of the francophone population. In this sense, the entities are excellent instruments for implementing this vision and ensuring that francophones have access to French-language health services wherever and whenever they need them. Consequently, the entities' role should go beyond consultation.

It seems inconceivable to me that we are still unable to prove to the LHINs what a key role the entities play for francophone patients. It's a deplorable waste of potential.

We believe that to enable francophones to live, grow and develop in French in Ontario, we have to expand the entities' role vis-à-vis the LHINs by allowing them to participate fully, as their names suggest, in the planning of French-language health services. Their expertise and knowledge regarding French-language health services make them not only key partners but critical partners for the LHINs.

On another note, I would like to draw your attention to the transparency of the Ministry of Health and Long-Term Care with a revision of the Local Health System Integration Act to enable health system organizations to fulfill their obligations with respect to the application of the French Language Services Act.

I would like to focus on the application of the FLSA and its regulations vis-à-vis the LHINs and the service providers.

The LHINs and the commissioner's office have been in a legal debate for a number of years. Although it is obvious to the commissioner's office that service providers are subject to the French Language Services Act and its regulations, the LHINs believe that since they do not provide health services directly, they do not have the power to delegate that obligation to service providers, and therefore they do not have to ensure that service providers are in compliance with the French Language Services Act. If this interpretation were to prevail, it would mean that health service providers could not be forced to provide services in French, even though those services are funded by the government.

It goes without saying that such an interpretation of the facts and of Ontario legislation is completely inconsistent with the history of French-language services in the province in the health sector, and certainly contrary to both the letter and the spirit of the Local Health System Integration Act and the French Language Services Act. In fact, the prevalence of health service providers is the main reason we worked so hard to bring in regulation 284/11 on third parties.

Accordingly, my recommendation is divided into two parts. First, the LHINs must work even more closely with the entities to identify service providers that will deliver health services in French. Once they sign an agreement

with the LHINs, those service providers become subject to the French Language Services Act, including regulation 284/11, and must comply with them.

Second, I remind you that in this scenario, the LHINs have an obligation to ensure that those service providers fulfill their obligations. Any failure to honour those obligations is a violation of the French Language Services Act, but most importantly, it can have serious consequences for francophone patients, as I pointed out at the beginning of this speech.

It is illogical for the LHINs not to take adequate measures to ensure that the health services provided by health service providers on their behalf meet the requirements of the French Language Services Act.

Worse, it is inconceivable to the commissioner's office that the French Language Services Act's application to health services funded by the LHINs would even be questioned. The Minister of Health and Long-Term Care has repeatedly stressed the importance of Bill 41, noting in particular that Ontario's francophones do not receive health services of equal quality and that those services are not always tailored to address their interests.

Adoption of the amendments that I proposed today would make it possible to turn words into concrete actions. I trust that in view of the recommendations made in my brief, you will consider the important, critical issues of francophone patients.

I would like to conclude by emphasizing the consequences of inaction. Action is needed now, because the health of the francophone population is at stake. My appearance here and those of the other organizations that presented their briefs over the last two weeks are perfect opportunities for the members of the Legislative Assembly to take immediate measures to remedy this unacceptable situation. It is my duty to stress the fact that these circumstances, which have persisted for too long, must be given priority in order to safeguard the health of francophone patients and language rights.

Je vous remercie à nouveau de m'avoir écouté. J'anticipe avec plaisir vos questions auxquelles je tenterai de répondre au meilleur de mes connaissances.

And I'm accompanied by Joseph Morin, our legal counsel at the office.

The Chair (Mr. Monte McNaughton): Merci beaucoup. We'll move to Ms. Kiwala.

M^me^ Sophie Kiwala: Merci beaucoup et bienvenue. J'ai apprécié énormément votre députation. Il faut que je commence avec les mots que—je parle français, mais pas tout à fait couramment. Mais, j'essaye quand même.

J'aimerais bien dire quelque chose à propos de la législation qui, je pense, est très importante. Premièrement, notre gouvernement est « committed » d'assurer la présence des Ontariens francophones dans le « planning », le design et la livraison de programmes de santé et de services aussi. La législation souligne exactement l'importance de faire—will make sure that the service est plus équitable pour the francophone community.

Ma question est que—il y a eu previous legislation, Bill 210, where we made important changes to the bill, recognizing in the legislation the importance of French language services. Your stories impacted me hugely because I used to live in Turkey. I've been sick in Turkey. I didn't speak Turkish fluently and it was a challenge. I know what the francophone community goes through when they're trying to receive health services, so this is very important to us. I just wanted to talk to you a little bit, and I know two minutes is almost nothing. We're not going to have enough time to get to a question.

Do you think that improving local health systems planning—

The Chair (Mr. Monte McNaughton): Ms. Kiwala, time is out. We'll move to Mr. Yurek of the official opposition.

Mr. Jeff Yurek: Thank you, Chair.

Je vous remercie pour votre députation—discours. Excusez-moi.

I'll switch to English so I get my question in under the two minutes. Two questions for you: With regard to the board make-up throughout the province, should we be looking to ensuring there's a certain percentage of francophones on the boards, either in relation to the population of the area the LHINs are serving, or just in general a certain amount to ensure that there is true representation at the board level?

M. François Boileau: Thank you for the question. I did not make it a specific point, though representation is always a good thing. I believe that if you are going to choose that route, a number of francophones, usually one or two on each LHIN, would greatly help, though when you have only one then that person sometimes becomes the token person who speaks only about French-language issues. When you have two, then you feel more confident to be more forceful.

So yes, I would certainly approve including in the board of directors two people from the francophone community, or francophile community as well. You're not going to pass a blood test to find out if you're really French or not. If you're speaking French, that's good enough.

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Mr. Jeff Yurek: My other question is with regard to the six entities that are out there. How can we ensure that the LHINs take hold of these groups and work with them? Is there something we should put in the legislation?

Mr. François Boileau: Absolutely. Right now the entities are under the LHINs. Over time, the LHINs have even asked the entities not to publish their own recommendations, because it was privy to the LHINs. This relationship needs to change, and in order to change this relationship, we suggest that we don't only engage the entities, but we consult with the entities and that they become key partners—

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Madame Gélinas.

Mr. François Boileau: It's in our brief.

M^me^ France Gélinas: J'aimerais que vous finissiez votre phrase là-dessus : « On veut que les entités de planification... »—là, je vous laisse finir votre phrase.

M. François Boileau: On veut que les entités de planification puissent avoir un rôle de partenaire, un rôle clé et non pas un rôle de subordonné. Donc, on comprend que le budget va être contrôlé par les RLISS, mais en même temps on souhaite que les entités puissent avoir un rôle accru au niveau de la planification, comme leur nom le suggère. Mais, en ce moment, ils ne sont pas dans un article où on parle de planification; ils sont dans un article où on parle d'engagement. Alors, ce serait important de les mettre sous l'article 14, où on parle de consultation. En ce moment, ils sont sous l'article—

M. Joseph Morin: Seize.

M. François Boileau: Oui. Pardon—l'article 15. Oui.

M^me^ France Gélinas: OK. L'autre question, brièvement: les tierces parties. Moi, j'ai des plaintes toujours que la personne qui vient donner les services à domicile ne parle pas un mot de français, dans une famille qui a toujours parlé français. Je sais qu'on a le règlement. Qu'est-ce qu'on peut faire dans ce projet de loi pour s'assurer que cela n'arrive plus jamais?

M. François Boileau: Le gros problème, c'est les politiques et les juridiques. Je vais parler des politiques très brièvement. Joseph va parler du juridique. Politiquement, avant la création des RLISS, le ministère avait une obligation directe avec les fournisseurs de services, et il n'y avait pas de problèmes. Mais, maintenant qu'on a créé les RLISS, c'est comme si, parce que ça passe par un autre organisme gouvernemental, là ça échappe aux contrôles—le règlement 284 sur les tierces parties ne s'applique pas, ce qui est un non-sens.

On propose, juridiquement—

M. Joseph Morin: Oui, trois choses :

Alors, premièrement—Joseph Morin—dès le début, il faut que les plans d'intégration des services de santé du ministère incluent des parties au sujet des services de santé en français.

Deuxième chose : il faut que les ententes de responsabilisation entre le ministère et les RLISS comprennent des parties spécifiques, des engagements spécifiques, au sujet des services de santé en français.

Troisièmement, les ententes entre les RLISS et les fournisseurs de services doivent comprendre—

The Chair (Mr. Monte McNaughton): Monsieur, we're out of time. Thank you very much for your presentation today. C'est fini. Merci beaucoup.

ONTARIO NURSES' ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll now call on the Ontario Nurses' Association. Welcome. You'll have nine minutes for your presentation. The questions will start with the official opposition afterwards. Just state your name for Hansard and begin.

Ms. Vicki McKenna: Good afternoon. My name is Vicki McKenna. I'm a registered nurse and the provincial first vice-president of the Ontario Nurses' Association. Joining me today is Lawrence Walter, ONA's government relations officer.

ONA is Canada's largest nursing union. We represent over 62,000 registered nurses and allied health professionals, as well as more than 14,000 nursing student affiliates. We provide care in Ontario's hospitals, long-term-care facilities, public health units, community care access centres, community clinics and industry.

ONA represents approximately 3,700 employees in 10 of the 14 community care access centres, or CCACs. The vast majority of our members are front-line health care professionals, including registered nurses, nurse practitioners, registered practical nurses, care coordinators, social workers, occupational therapists, physiotherapists, long-term-care placement coordinators, rapid response nurses, nurse clinicians, advanced-practice nurses, nurse educators and consultants in palliative and wound care, for example, as well as our allied health professionals.

In previous submissions to the ministry, ONA documented the high costs of care under the current competitive bidding/procurement model. We demonstrated the duplication of services and management structures in the delivery of home care services and the lack of continuity of care for patients and their families.

The Auditor General, in her 2015 annual report, similarly documented issues of duplication and omission in the CCACs who administer contracts with about 160—and, yes, it is 160—private sector service providers to provide home care services, and commented on the resultant commercial confidentiality in that model so that the true costs are left unsubstantiated.

In our submission on the Patients First discussion paper, we proposed an alternative model for the integration of home care delivery into the public, non-profit CCAC whereby efficiencies and client quality could be realized. The government chose to go in a different direction by dismantling the CCACs and transitioning the front-line care staff into the local health integration networks, or LHINs, while maintaining the proliferation of contracts for the delivery of home care services to a multitude of private, mainly for-profit, home care companies under the existing procurement contracts.

Bill 41 is the government's operationalization of that decision. Because of the government's decision, ONA took the position that in order to maintain continuity of care, the transition of staff we represent must maintain existing collective agreements, as well as the existing labour relations regime.

Bill 41 provides that the labour relations transition will be managed under the sale-of-business provisions of the Labour Relations Act and the Pay Equity Act to allow for the transition of ONA-represented staff to take place. We have also been advised that regulations will be introduced, if Bill 41 passes, to ensure staff are covered under the existing labour relations regime under which CCAC staff are currently covered.

The primary issue for ONA is gaining a solid understanding of how the structural transition proposed in Bill 41 will actually result in administrative and man-

agement savings that can be reinvested in front-line care in people's homes, as the minister insists is at the core of the transition.

Under Bill 41, home care services should continue to be provided by the more than 160 current service providers under the contract, as noted by the auditor. Further, as the auditor noted, "Home care used to serve primarily clients with low to moderate care needs, but now serves clients with increasingly more complex medical and social-support needs."

This proposed model for transition in Bill 41 seems to ignore all the evidence that has been raised regarding the duplication and inadequate home care service provision, while also underestimating the growing demand for home care services which requires significant upgrades in resources and capacity. Home care agencies which are not providing adequate service and/or not fulfilling their contract obligations in the current CCAC model will continue to be rewarded with patients being assigned to them under the model transitioned to the LHINs.

This duplication and omission significantly increases the workload and follow-up required by care coordinators who seek to ensure patients are receiving timely and consistent quality home care services. Our members tell us about referrals sent by care coordinators that are not fulfilled in a timely fashion, often as a result of retention and recruitment issues in the private provider agencies. However, there appear to be no repercussions for the private service providers. How will this transition to the LHINs make change if there is no change to the contracting of service providers under the proposed home care delivery model in Bill 41?

ONA's vision is quite different. We support the delivery of quality home care services in a public non-profit entity. That's why we are generally supportive of the initial transition of home care coordination to the public non-profit LHINs, although we know that the LHINs face issues of capacity as they move to take on home care coordination.

The next step to complete our vision is to transition the delivery of home care services to the same public non-profit entity.

Others have advocated for moving care coordination into some 445 primary care organizations across Ontario, rather than the LHINs. ONA firmly disagrees. Such a move would continue to fragment care and duplicate services between primary care and home care agencies. The services need to be consistent throughout the province, regardless of the employer of the care coordinator. This is one of the goals of Bill 41. Care coordinators working for more, not fewer, employers will not promote consistency.

CCACs/LHINs provide good jobs with competitive wages, benefits and pensions. This promotes retention and recruitment of valued health care providers. In the current structure, care coordinators who are on leave, vacation or sick time, for instance, do have co-workers who can back them up during absences. Small primary care providers do not have that ability or capacity. CCACs/LHINs can also provide surge and emergency coverage that cannot be provided by small primary care providers.

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In the meantime, under the proposed transition of home care services in Bill 41, the LHINs will be tasked with creating a combined management and administrative structure. It is to be noted that the multiple layers and number of CCAC management positions were not reduced with the merger of 43 CCACs into the current 14, as was expected. In this new proposed restructuring into the LHINs, we would expect significant reductions in management positions and that savings would be reinvested in front-line care in people's homes. The deputy minister has suggested that efficiencies might produce administrative and management savings in the range of 5% to 8% of the management and administration budgets of the former two entities. However, all indications at the moment, in terms of enhancing capacity in the LHINs, point to the expectation that the change-over practice may actually increase costs.

As a result, we are not optimistic that the obvious inefficiencies and wasteful costs will be properly addressed, given the continuation of managed competition models. Simply replacing the CCAC management structure with a new LHIN management structure is not going to reduce this waste of resources from duplication and the siphoning-off of profits by private providers.

Our vision, in which the LHINs directly employ all front-line staff responsible for home care delivery, would be a much better use of limited resources and would eliminate the needless and wasteful expenditures of resources on contracting processes. It would also result in a much better continuity of care and set consistent standards across the system, given the consolidation, rather than the fragmentation, of service delivery.

Further, dispensing with the current fragmentation of services between the CCACs/LHINs and the contracted private service providers would allow for public accountability and transparency for clients and families, rather than restrictions and barriers that are imposed by commercial confidentiality.

Ontario's managed competition model does not work, and tinkering with the structural locations from CCACs to LHINs will not lead to the fundamental renewal of home care services for our patients that they deserve.

LHIN renewal is the first step. For that reason, we are generally supportive of Bill 41, but structural change alone is not a sufficient precondition for a renewed public home care system where profit and waste are removed.

Thank you very much.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation. We'll move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thanks. Good to see you again.

Ms. Vicki McKenna: Yes.

Mr. Jeff Yurek: You made a note here about the deputy minister saying that efficiencies might produce 5% to 8% in savings. I've never seen any documentation

to back up or any kind of study to show that type of savings.

Ms. Vicki McKenna: Where we found that number?

Mr. Jeff Yurek: Yes. Do you have any idea?

Ms. Vicki McKenna: No. We've just been hearing that number generally across discussions with our leaders and members, that they are hearing that out in the field, that that's what the discussion has been and that's the expected savings.

Mr. Jeff Yurek: It's concerning that they are combining the two organizations and getting rid of the volunteers, as a way of quickly looking at it.

It would be nice to have those savings go to the front-line care.

Ms. Vicki McKenna: We agree—if they are there.

Mr. Jeff Yurek: My other note here was just on the administrative and management savings. Do you think there should be something put in the legislation to ensure any savings found are directed back into the front-line care?

Ms. Vicki McKenna: We would certainly agree with that. Any savings should be directed at home care provision in people's homes and out in the field, not in management back-structure, which we saw historically with the 40 down to the 14. There were no savings; there was no reduction. There was no change there. We just merged people and organizations together without limiting that.

Mr. Jeff Yurek: It's hard to create the integrated system when not enough money is making it to the front lines.

Ms. Vicki McKenna: Exactly our point. Thank you.

Mr. Jeff Yurek: Thanks.

The Chair (Mr. Monte McNaughton): Madame Gélinas.

M^me^ France Gélinas: Thank you. I'd say that I fully agree with you. I cannot for the life of me imagine how taking away the board of the CCAC and making their CEO a vice-president of community care in the LHIN is going to change one iota of anything for people who desperately need home care, are on waiting lists, have needs that big and get one bath every two weeks. That's not going to change.

The process that you are putting forward is rather interesting. It would be under the LHINs, for lack of a better place to put it, but then all of those contracts that need to be monitored and need to be managed would be done away with, and the staff would be employees of the LHINs, working together to deliver home care?

Ms. Vicki McKenna: Yes. Once upon a time, that's actually what there was. That was many years ago, when the staff who were in folks' homes were actually employees of the entity that was coordinating the care. They were able to train, manage, set standards and expectations, and follow up, which is now the big piece that's missing. We believe that that should be where we're going. That should be where we end up at the end of the day, if we really want to have consistent standards and access to care right across this province, no matter where you are.

M^me^ France Gélinas: So you figure that although we would continue to have 14 LHINs, we could achieve equity province-wide?

Ms. Vicki McKenna: I believe that's absolutely true. The local health integration networks are charged with responding to the care need provisions in their geographic region, certainly, but provincially, I believe the government has the responsibility and the accountability to set provincial standards such that you can expect to receive the care in your home, whether you're in Toronto or Thunder Bay or Timmins. There shouldn't be that disparity that we know is happening out there across the province today.

M^me^ France Gélinas: Or if your referral is in February rather than April.

The Chair (Mr. Monte McNaughton): Thank you very much. We're out of time.

Ms. Vicki McKenna: Thank you.

The Chair (Mr. Monte McNaughton): We're going to move to the government. Ms. Wong.

Ms. Soo Wong: Let me welcome you back here, Ms. McKenna.

Ms. Vicki McKenna: Thank you. Nice to see you.

Ms. Soo Wong: I should declare that I am a former member of ONA, from public health.

Ms. Vicki McKenna: Yes, I recall that. I remember that, yes.

Ms. Soo Wong: You know we've been talking about the continuity of care for a long time.

Ms. Vicki McKenna: Yes, a long time.

Ms. Soo Wong: Talk is cheap. Finally, we've got a government that is listening. I have yet to meet anybody who supports the CCACs. I'm going to be upfront about that. So I want to hear your perspective, Ms. McKenna—and Mr. Walter's, if you want to chime in; I know I have two minutes—in terms of elaborating on the changes that you hope to see. I know you kept saying in your presentation and in your written submission to us that there's a lack of continuity of care. I hear the concern about for-profit. How do you envision the home care sector in terms of better outcomes, better continuity and one-stop shopping? Because that's where the inconsistency is, right?

Ms. Vicki McKenna: We absolutely agree that that is where the inconsistency is. We believe that the siphoning off of profit in most of the home care agencies that are providing care contributes to fewer staff, and staff that aren't trained and don't have adequate working conditions. We know they're the poorest-paid in our health care system. They have a problem retaining and recruiting staff for that reason. It's really one of the most difficult forms of precarious employment in this province. We know that's something that the government is serious about addressing.

We believe this will do two things. One is to provide the consistency in training of care providers in our

homes. The other is to deal with some of the precarious employment situations that are happening.

Ms. Soo Wong: So bring that up, like we did with the PSWs, right?

Ms. Vicki McKenna: Yes. Exactly.

Ms. Soo Wong: We also heard, from previous presenters this afternoon, the concerns about the LHINs. Much of this elevated the role and the power of the LHINs. Do you want to comment on that, Ms. McKenna?

Ms. Vicki McKenna: I didn't hear the presentation earlier so much, and I don't know if Lawrence had anything to add to that—

The Chair (Mr. Monte McNaughton): With that, we are actually out of time.

Ms. Soo Wong: Thank you for being here.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation.

Ms. Vicki McKenna: Thank you.

ADVOCACY CENTRE FOR THE ELDERLY

The Chair (Mr. Monte McNaughton): Now I'll call upon Advocacy Centre for the Elderly. Good afternoon.

Ms. Jane Meadus: Good afternoon.

The Chair (Mr. Monte McNaughton): You'll have nine minutes for your presentation. If you'd begin by stating your name for Hansard, please, and then you can begin.

Ms. Jane Meadus: Good afternoon, Mr. Chair. My name is Jane Meadus. I'm a lawyer with the Advocacy Centre for the Elderly.

I'm the institutional advocate, which means that my job is representing people who are in long-term-care homes, hospitals and other institutions.

I'm here today with my executive director, Graham Webb, who is in the audience, as well as Bernadette Maheandiran, who is the primary author of the materials that you're receiving. You have received those materials by email as well, so I hope that you all have time to have a look at them.

I want to thank you for seeing us today.

The Advocacy Centre for the Elderly is a specialty legal clinic. We're located in Toronto and have been in operation for about 32 years. We provide a range of legal services, mostly to low-income adults in Ontario, as well as doing research, teaching various groups, from service providers to patients, and being part of various government committees, including those relating to care of residents.

Most specifically, the area of health law is about 65% of our legal clients. They have legal health-related issues. The most common issue that we deal with relates to hospital discharges: hospitals attempting to discharge patients into unsafe situations in order to avoid them going into long-term care.

In 2012, we had 200 cases of this type in a year, while in the first nine months of this year, we've had about 500 cases, so you can see the uptake is big. This legislation is potentially going to impact those clients quite well.

1400

What we see a lot in this bill, which we would think is helpful—overall, it's unclear how this is going to increase patient care and make patient care better. The first issue I'd like to draw your attention to is that of independence. It's imperative that this legislation ensure that the independence of the LHIN and CCAC roles is kept and not included with hospitals or other institutions. The legislation appears to allow for the downloading of these services by allowing the LHINs to delegate what the CCAC roles are related to home care and long-term care to a third party. This is not part of patient-centred care.

We're very concerned that this act and its delegation authority may have been deliberately included so as to allow for certain duties to be performed by hospital discharge planners and the like. We've already seen several programs which have been piloted across the province in different projects, and unfortunately, while they may streamline processes—and that is what the goal seems to be—what actually occurs is the hospital agenda to move people out of the hospital as quickly as possible overtakes the patient-centred focus.

We already see hospitals which we believe have illegal discharge policies putting a great deal of pressure on patients and their families or substitute decision-makers. Our ability to advise clients that they should speak directly to who the CCAC are presently in order to resolve these issues would disappear if it was now a hospital person. Unfortunately, for the hospital discharge planners and the like, their goal is to get people out of the hospital and not necessarily to act in the best interests of the patients. Should these lines be blurred with those duties to hospital staff, we will lose the independence of the CCAC role, and this will be anything but a patient-first service.

Another issue we'd like to discuss is the lack of equity in care and services in the home care sector across the province. At the present time, there's no transparency in this area, and there's no justification other than budget claims as to why some areas get more or different services than others. Again, this often relates to hospital-bed pressures in the area. For example, because hospital patients are blocking beds, there's a great deal of pressure on the hospital and CCAC to move patients into the community, despite the requirements of those patients for long-term care, and the issue of safety if they return home. However, given waiting lists for long-term care, patients may agree to go home because of the promise of large amounts of home care when they return. Unfortunately, these large amounts of supports take money away from those who are being managed already at home, cause waiting lists, and actually cause people to end up back in hospital, creating vicious circles. This means that in some areas discharged patients may get a high amount of care, but that takes away from the care that's being provided to others in the community.

You can see this type of problem in an area such as Etobicoke. If you're admitted to Etobicoke General

Hospital, you're in the Central West CCAC catchment area. However, you may live in one of four different CCAC areas that surround that hospital—Central West, Central, Toronto Central or Mississauga Halton—because Etobicoke has been carved up into those areas for LHINs and CCACs. Therefore, the same patient with the same issues may get very different services—and it is very complex for the patients to understand why they're getting one amount of service when the person in the next bed is getting a vastly different amount.

We're happy to see that the act amends the Local Health System Integration Act by promoting equity and reducing disparities in the system. We believe that this is one of the most important goals, as equity and health care are important to all citizens of Ontario. We'd also like to recommend that there be a review after three years to see if the implementation of that section has met that goal.

One of the changes between the original Bill 210 from last spring and Bill 41 was the exemption of public hospitals from the LHINs' authority to issue operational policy directives under section 20.2 and appoint a health services provider, pursuant to section 21.2. The exemption regarding long-term-care homes in that section makes sense because they're heavily being monitored and inspected by the Ministry of Health. However, we have no such oversight over hospitals. A large percentage of our health dollars go into hospitals, yet a criticism has always been that there is little oversight. We believe that hospitals are such a critical part of our health care system that they should be required to meet standards and bear scrutiny in order to provide the highest-quality services to Ontarians. We know of no valid reason why that should not be the case.

We're also pleased to see the inclusion of admission to rehab and complex continuing care hospitals in Bill 41. However, we would like a regulation authority in the act as well—so an amendment added to allow for regulations to be passed in this area. At present, there are no rules around what rehab or complex continuing care facilities are required to offer in this province. There's no transparency on who gets admitted, what the criteria are etc.

We'd also hope that this type of amendment would solve the problem of people being told that they aren't eligible for complex care, because we could get proper regulations around this. There are many people in hospital who are told that they aren't eligible for complex care, and yet their needs are far too high for long-term care. What happens is that they're told that they either have to go home or to a retirement home, which is a private tenancy—not part of our health care system—and they're put into harm's way.

We also have many calls from applicants where the applications for the rehab or complex care are not even sent when they're requested by the patient to do so. They are turned down and there's no explanation given, and when there is, the explanation can be based on inappropriate grounds, such as the age of the patient, where they live, the services they might get after they're finished rehab, for example. We believe that a centralized system that is similar to applications for long-term care, with equivalent transparencies, is important at this juncture. However, regulation-making authority is required in order to do that.

Finally, we would submit that this is the opportunity to make the Patient Ombudsman a true ombudsman and give her the independence that she requires to properly serve the people of Ontario by making her an officer of the Legislature, thus allowing her to be autonomous and making her truly independent. We also support amendments which would give her full authority over the LHIN instead of the pieces that she has at present.

The Chair (Mr. Monte McNaughton): Thank you very much. Madame Gélinas.

M^me^ France Gélinas: Thank you for this very good presentation as well as a very good submission. You always do good work, and you didn't fail us this time either.

The way I see it is that the board of the CCAC won't exist anymore, and the CEO of the CCAC becomes a VP of the LHIN, responsible for community services. Do you figure that will help any of the clients who have come to see you for health care or for access to home care?

Ms. Jane Meadus: I don't really see that that's going to help much. I think we're just going to end up with a larger bureaucracy, because now we're going to have sub-LHINs, as well. I don't see that the change in the structure—I understand that the Auditor General wanted one, but I don't see the change in structure as actually really helping when you're looking at patient-centred care. That's not where the problems really lie.

M^me^ France Gélinas: I agree with you.

A problem that I brought to you a number of times, and I don't know if this is my opportunity: couple reunifications, in two different nursing homes. If they're not crises anymore, they wait and wait and never get together again. Can you give us some thoughts as to how we should handle this?

Ms. Jane Meadus: The problem is that we don't have enough long-term-care beds in Ontario. We have 5,000 people in hospital—they're getting pushed into the community and into unsafe situations. They're being told, "Leave the hospital and become a crisis." Then you end up with 30, 40, 50 people on a crisis list, and even though spouses are the second level of category, they're never going to get to the top. They're always getting bumped. So the problem is the bottleneck into long-term care.

The use of retirement homes is not the answer either. They're not health care facilities.

M^me^ France Gélinas: Agreed. You made a good list of changes.

I'm not sure I fully understood the delegation—the LHIN can delegate any of its powers. So you're afraid that if the LHINs delegate powers to the hospitals, then the power of a case coordination—

The Chair (Mr. Monte McNaughton): We have to move to the government for questions. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much, Jane and Bernadette, for being here today and for the excellent deputation.

I just want to underline a few things about the legislation. The primary focus that's driving it is to deliver the right care at the right time in the right place. It's important that we ensure that health equity is something that we strive for. It has been a very important feature of this piece of legislation. We're hopeful that the Patients First Act will help us achieve this goal. It is a transformative piece of legislation, and it's going to certainly require all parties being at the table.

I'm wondering if you can speak a bit on how your members have seen health inequity across the system and how you would like to see Patients First address this through not just the legislation, but also through implementation.

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Ms. Jane Meadus: Well, I think the number one issue we do have is with respect to access to long-term care. We are seeing more and more people pushed into the community and told that they have to provide their own services, pay for services. They are told to sell their house, mortgage their house and pay for a retirement home because they're not going to long-term care because there is no long-term care. That's probably the biggest thing. We get probably five or six calls per day, hundreds a year. That's where the bottleneck is, and that's where we get the most complaints.

Ms. Sophie Kiwala: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today. It's a great report you gave us.

I guess just some comments: You touched a bit about the Patient Ombudsman. We had the Patient Ombudsman here last week—Monday, I guess. Her concern was the conflict of Health Quality Ontario and the fact that she's not independent and was calling for independence.

It does raise the concern of oversight of the LHINs. The Auditor General said that they have failed in providing integration of the health care system. There was a LHIN review that wasn't done, so we don't know how ineffective these organizations are, and now they're getting more power.

If the government is not going to move to make the Patient Ombudsman independent, how else do you think we could achieve some oversight of the LHINs?

Ms. Jane Meadus: Obviously, the Ontario Ombudsman has some authority now. I think the problem is that it's fractured, so there will be some power for one person or another. I think that's part of the problem. You have to make somebody—if you've got a LHIN, for example, one person has to have some oversight. That's the same problem with hospitals. Nobody has oversight of hospitals on a daily basis. You can't call the ministry and say, "Hey, we have a problem. Go in and look." They won't. So we really have to look at the sector and say, for all of these players who are providing such a vital service, somebody has to have power over them. It's just not happening now.

Mr. Jeff Yurek: With regard to long-term-care homes, I totally agree with you that we have a severe shortage. It's one of the higher concerns in my office—getting a call that mom or dad can't find a place and they're stuck in the hospital, which is more expensive at the end of the day.

So this bill, in your opinion, will do nothing to improve the long-term-care situation.

Ms. Jane Meadus: No.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Monte McNaughton): Thank you for your presentation.

COALITION OF ONTARIO DOCTORS

The Chair (Mr. Monte McNaughton): We will now move to the Coalition of Ontario Doctors. Good afternoon.

Dr. David Jacobs: Good afternoon.

The Chair (Mr. Monte McNaughton): You'll have nine minutes for your presentation. If you would just begin by stating your name for Hansard, and you may begin.

Dr. David Jacobs: Absolutely. I'll keep it nice and brief for everyone. Hi, there. I'm Dr. David Jacobs. I'm here for the Coalition of Ontario Doctors. You can all read along with my paper as we go forward.

Good afternoon, committee members. I'm Dr. David Jacobs. I'm a radiologist working in Toronto and Thunder Bay. I am also the chair of the OMA section on diagnostic imaging. I appreciate having this opportunity to appear before the committee to share my serious concerns and offer recommendations regarding Bill 41, the Patients First Act, 2016, which is a deeply flawed piece of legislation.

I am here on behalf of the Coalition of Ontario Doctors, an organization that represents thousands of community and academic family doctors and specialists from across Ontario. The coalition formed four months ago to oppose the physician services agreement developed secretly by the Ontario government and the Ontario Medical Association that, if passed, would have cut millions of dollars from the provincial health care budget and forced front-line doctors to pay for the skyrocketing costs of the health care system over the next four years.

The PSA was soundly rejected on August 14. Since then, the coalition has worked hard to push for fundamental reforms to the negotiation process and to develop a new PSA that would be good and fair for patients and for doctors. At every turn, our efforts have been rebuffed by both the OMA and the Ontario government. However, we remain steadfast in our view that reform must take place. We will not stop in our efforts to bring change to this area of health care on behalf of Ontario's patients.

As the OMA and the Ontario government remain at a crossroads regarding the future of funding for physician

services in the province, front-line doctors are being forced to confront the prospect of a law that proposes radical change to the circumstances governing how they practise medicine. I'd like to turn my attention to this now.

Bill 41 concerns: First, Bill 41, the Patients First Act, is a marketing sham. To us, it appears that the only thing the bill puts first is the government's interest in controlling when and how people see their own doctor. This bill is not about better coordinating the provisions of disparate health care services in Ontario communities. It's about consolidating power and decision-making in the hands of the Minister of Health and Long-Term Care and via the province's local health integration networks with a primary aim, we suspect, of controlling how health care resources are spent.

Second, stakeholder consultation on Bill 41, a bill that proposes to change or delete at least 20 different laws in the province, has been scant at best. The coalition certainly was not consulted. Beyond this, I do not believe that there were any serious or sincere attempts by the government at any time to obtain the views and input of front-line doctors on the bill. Even regarding Bill 210, which was introduced and died in the last legislative session and forms the core of Bill 41, Ontario doctors were not involved in the legislation's development. It suggests to me that the government does not want or care for the views of Ontario doctors on important health system transformation proposals, which is both sad and offensive.

Third, as a doctor who has witnessed the government's administration of the health care system from the inside, as well as a taxpayer, I am concerned about the public resources that will be used to create even more health care bureaucratic infrastructure in the form of LHIN sub-geographic regions, which the proposed legislation mandates be created for the purposes of planning, funding and service integration.

In my view, the additional layer of bureaucracy is not what patients and our health care system need at this time. What is needed is to maximize health care spending on front-line health care services. It is not right that Bill 41, instead of supporting front-line patient care, directs funding to a whole new level of bureaucratic health care decision-making—not to a hospital ER, not to community clinics, but a whole new level of health care bureaucrats who may also have access to patients' confidential health records.

I want, at this point, to bring up what the privacy commissioner has said. The commissioner has commented on this, and in the report it says that the IPC recommends that section 29 of Bill 41 be amended to clearly state that regulations made pursuant to that section cannot authorize the disclosure of personal health information to LHINs.

Patient privacy is paramount. Patients come to us with information that they will not share with their family, they will not share with their spouse. They certainly don't want to share it with an anonymous bureaucrat. It is nobody's business but theirs, and it is under the protection of the physician. We have a duty to maintain their privacy. This legislation undercuts the doctor-patient relationship and it will affect people's willingness to discuss important health care information with their physician, lest that become knowledge to a third party—unacceptable.

The coalition, over the past six months, has more than 21,000 signatures for our petition against Bill 41. We've sent that, and to date we have heard nothing in response.

In conclusion, the Coalition of Ontario Doctors opposes Bill 41 on the grounds that it does nothing but centralize control of local and provincial health care decision-making among political and bureaucratic officials in the Ministry of Health and Long-Term Care and the LHINs, thereby excluding other stakeholders directly involved in health care service delivery in the community. This, we believe, is not in the best interests of patient care.

It is also clear that the government is not interested in working with front-line physicians to transform the provincial health care system in a way that will improve patient access to care and save money. We strongly encourage the government to abandon Bill 41 and commit to working with us and other health care professionals to bring positive change to the system.

The Chair (Mr. Monte McNaughton): Thank you, Doctor. We'll move to the government. Mr. Fraser.

Mr. John Fraser: Dr. Jacobs, thank you very much for being here today and thank you for your presentation.

I want to allay a couple of your fears. I realize that you're in a conflict with the bargaining agent that we have through the government, the OMA. But we did consult with them on a number of occasions. I'm not going to list all those occasions, but I want to assure you that that happened—number one.

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Number two: I want to assure you that patient privacy is at the top of the order. That's why we passed legislation last year that increased the fines, and I think you'll see a clarification inside this bill as to what the Information and Privacy Commissioner said.

I know there's a challenge, and there's an issue of relativity, that exists inside the organization. I sympathize a lot with family docs because family docs have a challenge inside their organization in terms of being represented and valued the way they should be in the system. They're in competition with specialties. We know that's happening in medicine across the world. It's a real challenge.

I'm interested in stewardship, because doctors are one out of every 10 tax dollars. Can you tell me, specifically, an instance of stewardship either at the local level or by an association level, where you're demonstrating stewardship over the system?

Dr. David Jacobs: First of all, I'm going to thank you for the kind words, and I'm going to challenge you. You say that you don't want to get into all the different ways in which we were consulted. I challenge you to provide me with a few of them, because I'm part of the OMA—

Mr. John Fraser: I will, after.

Dr. David Jacobs: All right, we'll talk about that. I also challenge you to follow the recommendations of your own privacy commissioner. I would like to see that. It's in there.

Mr. John Fraser: Yes.

Dr. David Jacobs: You're going to follow those recommendations?

Mr. John Fraser: What you'll see is, that will clarify—

Dr. David Jacobs: You are going to follow the recommendations of your privacy commissioner?

The Chair (Mr. Monte McNaughton): With that, the two minutes of questioning from the government is over.

We'll move to Mr. Yurek.

Mr. Jeff Yurek: Thanks, Dr. Jacobs, for coming in today.

Just to follow up: We've had the OMA here at committee, who stated they weren't consulted on Bill 41.

With the government saying their bill last year, Bill 119, may have added some penalties and fines to patient record confidentiality—however, they did open up the access to patient records through Ministry of Health staff, if they're directed by the Minister of Health. He can access patient records. He forgot to clarify that.

We've heard "no consultation" from patients, patient groups we've had here, doctors, the OMA, other doctor groups. How do you create an integrated health care system without including patients and doctors?

Dr. David Jacobs: You simply can't. It's a noble cause to try to reform our health care system. I think it's a good idea; it's necessary. But to do it with a top-heavy central command and control, absent consultation, is irresponsible, and I guarantee you it's a recipe for failure.

The Chair (Mr. Monte McNaughton): Madame Gélinas.

M^me^ France Gélinas: I agree with you 100%. I cannot believe that we would bring forward a reform that has the possibility to change the way that each and every physician in our province will practise and not talk to them. It's hard to believe.

Coming back to the privacy breaches—I'll call them that—that are allowed by the provisions of this bill, you've given an example. You've explained, on a one-patient basis, what it will do to that person. Do you also see an effect on your profession as a whole if people lose confidence, that the information they share with you will be shared with the government or a LHIN-appointed—

Dr. David Jacobs: Absolutely. To tell me that there are going to be greater fines if somebody looks at your health care record—that doesn't provide anybody with any solace after it has been examined. People out there have things they do not want to share. They have addiction issues. They have alcoholism. All of this has great impact on their health, and if they do not share that with their health care provider, their health suffers. They have mental health issues. They don't want the government knowing about that, nor should the government know about that. They don't want that to be found out by future employers. They don't want that to be shared with insurance companies. An additional fine is no solace when that privacy has been breached. A breach of that privacy will result in less and less reporting of these serious health care issues, and that will not enable us to take care of these patients.

M^me^ France Gélinas: Do you see a way forward where we could restore a relationship between this government and members of the medical profession?

The Chair (Mr. Monte McNaughton): Madame Gélinas, that's all the time.

Thank you very much, Doctor, for your presentation today.

Dr. David Jacobs: Thank you very much for your attention.

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

The Chair (Mr. Monte McNaughton): I now call upon the Canadian Mental Health Association, Ontario Division. Good afternoon. If you would each state your name for Hansard and then begin with your nine-minute presentation.

Ms. Camille Quenneville: Thank you, Mr. Chairman. My name is Camille Quenneville. I'm CEO of the Canadian Mental Health Association, Ontario Division. I'm delighted to be joined by my two colleagues today, Rebecca Shields from our York region and South Simcoe branch and David Smith from our Peel-Dufferin branch.

The Canadian Mental Health Association was founded in 1918 and is the oldest health charity in the country. There are 30 branches in Ontario and a total of 120 across Canada. In Ontario, we provide case management support, housing services, counselling, court- and justice-related services, seniors and family programs, workplace mental health services, to name just a few from the myriad that we deliver.

Our views expressed today represent the interests of all of our members. CMHA Ontario welcomes efforts to help integrate care in the best interests of the patient or client. We believe that a more coordinated system can positively impact individuals living with mental health issues and addictions. We are very aware that these are the people who most often experience barriers to care.

Ms. Rebecca Shields: Our clients often have difficulty accessing the proper primary care supports they need. We work hard to assist them with these supports, and in fact some of our branches offer these services. However, ensuring that all the needs of clients or patients struggling with their mental health or addictions requires much better coordination across the system.

We are generally supportive of the sub-LHIN structure, as proposed. We hope and believe that better planning will result. That said, we are also well aware that mental health and addictions are not a primary focus of the intended changes in communities.

The Ministry of Health and Long-Term Care announced the leadership council on mental health and addictions 18 months ago to provide advice to the minister. As an active member, we've been working hard on many fronts to propose solid and workable changes to the system. We hope that consideration is being given to including this work in the proposed changes that will happen as a result of Bill 41. In other words, it's a timing issue. We need to ensure that the voices of those in the mental health and addictions field and the council are heard throughout this process and not after structural changes on the ground have taken place.

We would like to raise two other significant issues with you. We know the committee has heard these concerns already, but we must add our voice to the growing chorus.

Ms. Camille Quenneville: Supervisory power of LHINs: We believe it's inappropriate to delegate, through Bill 41, significant and new authorities to LHINs in the absence of greater direction from government on how these new authorities are to be deployed.

We recommend that the power to appoint a supervisor for a health service provider, as described in section 21.2, should be changed to require the appointment be made by the Minister of Health and Long-Term Care.

We know there are circumstances when a supervisor must be called in to manage an organization. Recent history shows us that this has happened in both hospitals and school boards. For hospitals, a supervisor is appointed by the Lieutenant Governor in Council and cabinet on the recommendation of the minister, as prescribed in the Public Hospitals Act. The same is true under the Long-Term Care Homes Act, as the minister is required to appoint an inspector for these facilities under this piece of legislation. This also holds true in education, where the minister has the authority to appoint a supervisor to take over the affairs of a school board.

Health service providers deserve no less oversight, in our view. We respectfully request that this same oversight be provided from the Minister of Health and Long-Term Care and also request the following: that the term "public interest," as stated in the act, as the criteria for appointing a supervisor be clearly defined, and that an appeal process be established, so that health service providers and their local governance structure has a voice.

We recommend that parameters be set in place with regard to a funding threshold from the LHIN before supervisory powers can be enacted. Many agencies have multiple funders. In its current state, the LHIN will be able to exercise the option to engage a supervisor, even if they provide a small minority of funding to the entity. This is inherently unfair and must be remedied.

Finally, we recommend that the province consult with representatives of health service providers affected by these new provisions on the appropriate scope of the new LHIN authorities.

Mr. David Smith: CMHA Ontario is part of a partnership with other community organizations under the umbrella of Community Health Ontario. The other organizations include the Association of Ontario Health Centres, Ontario Community Support Association and Addictions and Mental Health Ontario.

We have a collective concern about the potential to contract out community support services to for-profit organizations as a result of legislative and structural changes between the LHINs and community care access centres. We understand that this matter is being reviewed by the ministry, and we will continue to monitor it with a view to a successful outcome.

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I'd like to thank you, Mr. Chair and members, for your time today. Thank you to Clerk Trevor for his efficient response to our request to participate.

We're pleased to answer your questions.

The Chair (Mr. Monte McNaughton): Great; thank you. I think you're trying to get the Clerk a raise. He does do a good job.

We'll move to questions from the official opposition: Mr. Yurek.

Mr. Jeff Yurek: I, too, would like to thank the Clerk, Trevor, for the work he does here at the Legislature.

Thanks very much for being here today. You're not the first to bring up the fact of a supervisor being applied to an organization which only receives a minor amount of funding from the LHINs. Is that a large concern with CMHA? I'm assuming you have other funders.

Ms. Camille Quenneville: We do have other funders from other ministries. We fundraise dollars. We are very focused on getting grants for a lot of the work that we do.

I just want to thank you, Mr. Yurek, for putting a couple of questions forward to legal counsel on this matter. We are aware of the responses they provided. They were pretty unsatisfactory.

Mr. Jeff Yurek: Okay. Thank you very much. In addition, I've noticed, with regard to addictions in general—we have an opioid crisis going on in the province. Do you see anything in this bill that's going to help coordinate care in our community with regard to addictions?

Ms. Camille Quenneville: I could spend about three days talking about the opioid crisis, so I'm going to focus on the care in the community that you describe and just simply say that I know that every population thinks that they're unique. I would argue that we are really unique, in that no other population suffers from the stigma and discrimination that our patients and clients suffer from.

Our view and hope and belief is that if there is a better coordinated system locally, that is more accessible, that can get our clients the primary health care that they need, not just the support they need for their mental health or addictions, that is a good thing.

Our concern is that the leadership council, of which I am a member, is working awfully hard to provide very good and solid advice to the minister—

The Chair (Mr. Monte McNaughton): Thank you very much. We have to move to the third party: Madame Gélinas.

M^me^ France Gélinas: Thank you for coming. It's always a pleasure to see you.

Supervisory power: I can guarantee you that we will make amendments to fix this. It makes no sense.

"Define the public interest": Have you put forward a definition that you would be willing to live with, or are you leaving that up to us to do that work?

Ms. Camille Quenneville: We haven't put it forward. We could certainly work on it. We're happy to do that with you.

The public interest is so broad. I don't know how it could be defined—or, I should say, I will be interested to see how it's defined, if we get to that point.

M^me^ France Gélinas: Okay. You talked about the funding threshold. When it comes to appointing a supervisor, have you got an idea as to where this threshold would be? Would it be specifically for LHIN-funded or for all ministry funds? How would that work?

Ms. Camille Quenneville: I think it would be all ministry funds. I can tell you that there isn't one of my 30 branches across the province that is solely funded by the Ministry of Health. My colleagues could perhaps speak to that, if you'd like.

Ms. Rebecca Shields: Certainly. We would find it difficult. With funding from United Ways or our philanthropists in some of our programs, they may not appreciate changes, or supervisors taking over, that would change the direction that they've given us in utilizing their funds. It might hamper us to be able to deliver services that are not core functions.

M^me^ France Gélinas: What's the percentage right now that your organization gets from the ministry versus LHINs versus other?

Mr. David Smith: We are 90% LHIN, 9% region and 1% United Way and philanthropy.

Ms. Camille Quenneville: And that's different across the province. There are 30 different responses on that.

M^me^ France Gélinas: Okay.

The Chair (Mr. Monte McNaughton): Thank you. We'll move to the government, and Ms. Wong.

Ms. Soo Wong: Thank you very much for being here. I'm very pleased to see that you've been able to participate in today's public hearings.

As the largest community-based mental health agency in the province, I'd like to hear your opinion in terms of local health planning, particularly improving the inequity of health services. I come from a very diverse community. I need to hear from you: If passed, how will this bill support and address this inequity?

Ms. Camille Quenneville: I think that's a very important point, and I'm very glad you raised it. I can assure you, our organization does a tremendous amount of work in equity. I'd be happy to send you a lot of it.

In terms of how that would work on the ground—and my colleagues can certainly join in—our branches are very well trained and manage these issues, I think, exceptionally well. It would depend on what the world looks like when this transformation is complete. How individuals have the ability to access services, I think, is what you're getting to, and how we could assist in that. I think there are a myriad of ways.

I'm happy to follow up with you on that.

Ms. Soo Wong: Any other of your colleagues?

Ms. Camille Quenneville: David has the highest population.

Mr. David Smith: The question specifically is?

Ms. Camille Quenneville: Around diversity and how we would reach out locally to individuals.

Mr. David Smith: We reach out to diverse communities constantly. It's part of who we are and how we engage with populations. I don't know if the act particularly makes any change to that. We have our constituents, and our boards are representative as well.

Ms. Rebecca Shields: I think the issue is around complex care patients, where we can better integrate with those that are, say, seniors with addictions that are also receiving services from the CCAC: Is there a possibility of better-integrated, more thoughtful planning and a quality framework that crosses both sectors?

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation. Time goes by quickly.

Ms. Camille Quenneville: Thanks, Mr. Chairman.

CONCERNED ONTARIO DOCTORS

The Chair (Mr. Monte McNaughton): We'll now call the Concerned Ontario Doctors. Good afternoon.

Dr. Kulvinder Gill: Hi, there. Good afternoon.

The Chair (Mr. Monte McNaughton): If you would just begin by stating your name for Hansard, Doctor. You'll have nine minutes for your presentation.

Dr. Kulvinder Gill: Thank you. Good afternoon, everyone. My name is Dr. Kulvinder Gill. I am a community physician and the president of Concerned Ontario Doctors.

Concerned Ontario Doctors is a grassroots, not-for-profit organization representing thousands of community and academic family physicians and specialists in every corner of this province. We advocate for a patient-centred, sustainable, accessible and quality health care system.

I thank you all for the opportunity to address the standing committee today about Bill 41, legislation that will directly impact the health care access and delivery of patient care of nearly 14 million Ontarians.

Ontario's doctors have grave concerns over Bill 41, an act that puts patients last. It has left thousands of front-line physicians—family doctors and specialists alike—fearful of the direction in which the government is taking Ontario's health care system. It is unfathomable that the government has introduced this legislation without any consultation with Ontario's physicians, the very physicians who provide essential medical care for 155,000 of Ontario's patients every single day.

Ontario's doctors have been without a contract for over two years, and during this time, the government has subjected us to senseless, unilateral cuts that have

directly impacted our ability to deliver timely and quality patient care.

Instead of collaboration, this government has chosen to vilify and shame Ontario's doctors. Effective health care reform requires meaningful and respectful engagement of all stakeholders in the province, including physicians. It requires genuine collaboration. Sadly, none of this occurred with Bill 41.

Front-line physicians are witnessing the crumbling of our health care system. We are struggling to keep our system afloat. We are struggling, trying to explain to our patients why we can no longer provide them with the care they so need and deserve. Ontario deserves better. Bill 41 will only make it more difficult for physicians to deliver the care our patients need.

The theme of prioritizing bureaucracy over front-line care carries into the restructuring of Ontario's LHINs. Two Auditor General reports have concluded that patients' needs have not been met by either LHINs or CCACs. Bill 41 is flawed if it expects improvement in patient outcomes with the merger of two failed organizations.

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With Bill 41, LHINs will not only have an increase in the size of their supervisory board, but an increase of 80 or more new sub-LHINs under their charge. At a cost of $90 million a year, the LHINs were just criticized last year by the Auditor General as being an ineffective, expensive drain on health care. She stated that the LHINs "have not achieved their mandate of providing the right care at the right time in the right place consistently throughout the health system" and that "LHINs performed below expected levels." It is a complete disservice to Ontario's patients to expand ineffective and wasteful bureaucracy at a time of such drastic funding cuts to front-line patient care. Creating more and more layers of bureaucracy is not the answer. We already have 0.9 bureaucrats per 1,000 population compared to Germany's 0.06 bureaucrats per 1,000 population. Expansion of health care bureaucracy has never led to improved patient outcomes in any health care system in the entire world. Ontario must heed this global warning.

It is concerning that Bill 41 will take away oversight of the LHINs from the Ontario Ombudsman and place this oversight with the Patient Ombudsman, who directly reports to the Ministry of Health. This is a direct conflict of interest and is especially concerning given that just last year the Auditor General stated, "The ministry takes little action to hold the LHINs accountable...." Bill 41 will allow bureaucrats to determine provincial medical standards of care. We have recently witnessed several government-led health care disasters, from the stem cell transplant program to eHealth, when political interests take precedence over patient outcomes. Provincial medical standards must be left to the medical experts, be evidence-based and be built upon the patient-doctor relationship.

Bill 41 expands on the privacy infringements of Bill 119, the Health Information Protection Act. It is very disturbing that Bill 41 will give bureaucrats access to patients' private medical records. No such legislation exists anywhere else in Canada. This is a direct threat to the patient-physician relationship. Patients share their deepest and most vulnerable concerns and worries with their doctors. Strict confidentiality allows for this level of trust and for the disclosure of health care concerns typically painted with a brush of stigma, including struggles with mental health, addiction and violence. All patients have a right to their privacy. This right must be preserved at all costs.

I present to the standing committee today a petition to stop Bill 41—a petition organized by Concerned Ontario Doctors and the Coalition of Ontario Doctors—which has quickly garnered over 21,000 signatures from Ontarians who want this government to take immediate action to stop Bill 41. It is time to protect patients against the invasion of their privacy. It is time to get rid of the bureaucratic elephant in the health care system. Bill 41 is seriously flawed. Ontario's patients deserve better.

Thank you for your time.

The Chair (Mr. Monte McNaughton): Thank you very much. Madame Gélinas.

M^me^ France Gélinas: Thank you, Dr. Gill. You've made some very powerful points. If we take them one by one, if we look at the invasion of privacy, I read the bill the same way you do: that under certain circumstances, the LHIN-appointed workers—we don't know who those people are—will gain access to our personal records. What will that do, not only to the relationship between that particular physician and their patient, but to the medical profession as a whole?

Dr. Kulvinder Gill: Currently, the reason patients share so much of their personal life, so many of their deepest and darkest secrets, with their doctors is because they know that that conversation is not leaving that clinic room. Oftentimes, before even sharing very sensitive information, patients will ask, "Will this information be shared with anyone else?" Presently, we can reassure them that it will only be shared with others with their explicit consent. We will not be able to assure them of that anymore. Without that assurance, I am fearful that patients will no longer share stories of violence, they will no longer share stories about addiction, they will no longer share stories about abuse. It puts the most vulnerable patients in our province in an even more vulnerable state, and that's something that we need to stop.

M^me^ France Gélinas: Agreed.

You talked about other parts of the bill that are problematic to the point where you want us to scrap it altogether. When you talk about the sub-LHINs and the bureaucracy, except for the money, are there other reasons why you are opposed?

Dr. Kulvinder Gill: I can tell you that there's not a single front-line physician in this province that knows what the LHINs do.

The Chair (Mr. Monte McNaughton): Thank you. We're going to move to the government for questions now: Mr. Fraser.

Mr. John Fraser: Thank you very much, Chair. Thank you very much, Dr. Gill, for being here today, for your presentation and for the work that you do.

I am perusing this because the Fraser Institute just reported today—just to allay some of your fears—that we have the lowest wait times between GP and receiving the actual service that you need, between GPs and specialists, in all of Canada. We also have the lowest wait times in Canada for CT, MRI and ultrasound—of all the provinces. The reason that I say this is that I think regional health care planning is critical to getting those kinds of results, because you can focus on what your capacities and what your needs are.

If I take a look at our local LHIN, we've done things with a great deal of success around teen suicide prevention, around addictions in teens in schools, and actually increased graduation rates. There's a great capacity to build local solutions to local problems. The doctor that appeared here yesterday, from Brantford, telling me about the wonderful work they're doing coming together: I think this bill actually creates that opportunity.

Because we did, in a previous deputation, talk about privacy, I just want to assure you that we are working with the Information and Privacy Commissioner. We did pass a piece of legislation last year which is the strongest in all of Canada in terms of the protection of health information. We talked to the commissioner. We understand what those concerns are.

That's what happens when you draft legislation. Somebody says, "Well, this might be a bit of a challenge." So we're going to address that. You'll have to see, of course, when the amendments come out, but we realize that there is a concern. That concern that was expressed needed to be addressed by the Information and Privacy Commissioner and for greater understanding with our physicians, in particular, and especially with patients.

Dr. Kulvinder Gill: Frankly, I'm going to disagree—

The Chair (Mr. Monte McNaughton): Thank you. We have to move to the official opposition. We only have two minutes for questions. Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair. Thanks, Doc, for coming in today. I will note, however, that this government likes to pick and choose which reports. If they had ever followed the Fraser report with regard to economics and how they're fiscally running this province—they change the tune.

In reality, we look at the Commonwealth Fund report. Canada is usually 11th or 12th out of other nations. They're promoting that they are the best in Canada. Canada is still ranking pretty low. I'd rather be much better than we are right now. We can't rest on our laurels. Bill 41 is far from achieving that.

However, with the attack on doctors that this government has had over the last two years, without consulting to create this legislation, where do you see health care going if they continue on this path?

Dr. Kulvinder Gill: To quote the same Fraser study that was mentioned, that same study also showed that wait times have never been this long in 20 years. I think that's an important distinction. This government likes to tout its own record while wait-lists in the province are crumbling.

What this Fraser Institute study also fails to capture is real-time data that's happening right now. We know that in the past year alone, over 200 family doctors and specialist clinics have actually closed or actually decreased their patient services, impacting nearly a quarter of a million patients in the province.

I think this government needs to be respectful of Ontario's physicians and all health care providers and truly engage with genuine collaboration to address this health crisis that they have created.

Mr. Jeff Yurek: Am I good?

The Chair (Mr. Monte McNaughton): Twenty seconds.

Mr. Jeff Yurek: Twenty seconds. Well, I agree, and I truly want to thank the coalition for standing up for patients in this province. I hope you continue to do so, and hopefully the government comes around and stops their vilification of family doctors and specialists throughout this province.

Dr. Kulvinder Gill: Thank you.

The Chair (Mr. Monte McNaughton): Thank you, Doctor, for your presentation today.

Dr. Kulvinder Gill: Who can I leave the petition with?

The Clerk pro tem (Mr. Katch Koch): I'll take it.

The Chair (Mr. Monte McNaughton): The Clerk.

1450

ONTARIO ASSOCIATION OF PARAMEDIC CHIEFS

The Chair (Mr. Monte McNaughton): I now call upon the Ontario Association of Paramedic Chiefs. Good afternoon. You'll have nine minutes for your presentation. If you could just state your name for Hansard, you can begin.

Mr. Neal Roberts: Thank you, Mr. Chair. Good afternoon, committee members. My name is Neal Roberts. I am president of the Ontario Association of Paramedic Chiefs. I am pleased to have this opportunity to provide comments to the Standing Committee on the Legislative Assembly and to contribute to the deliberations on the proposed Patients First Act.

The Ontario Association of Paramedic Chiefs represents paramedic services leadership in 52 designated delivery agents, consisting of regional, county and municipal governments, and district social services administration boards across Ontario. Our members include every DDA, Ornge, and three First Nations emergency medical services.

Ontario Association of Paramedic Chiefs members oversee the work of 8,000 primary care, advanced care and critical care paramedics as well as ambulances, emergency response vehicles, emergency response helicopters and fixed-wing aircrafts across the province. We are the

leading authority for paramedicine design and delivery in Ontario.

The Ontario Association of Paramedic Chiefs promotes a culture of change surrounding paramedicine that is guided by evidence-based decision-making and seeks best practices in the provision of service.

Paramedics often act as a portal for patients accessing the health care system. As a result, we experience firsthand many of the inequities in health care delivery and health outcomes that the government is looking to address through Bill 41. That experience has led the Ontario Association of Paramedic Chiefs to believe that deeper integration of paramedics into Ontario's health care system would both improve patient outcomes and reduce strain on our health care dollars.

We are here today to request that the committee strengthen Bill 41 by designating paramedic services and paramedics as health service providers. Paramedics are the pre-hospital point where evaluation of care commences. Being recognized as part of the health care system, and not an offshoot, allows partnerships to grow amongst the LHINs and the area hospitals. For this reason, we request that the province fully fund the implementation of community paramedicine programs in areas of Ontario where local councils believe these programs are feasible and where they want to develop and deliver programs specific to the needs of their residents.

The vast majority of 911 calls are not life-threatening. In these instances, paramedic services are confronted with issues that stem from aging, violence, mental health challenges and poverty. According to a 2012 study, Canadian seniors represent 60% of paramedic services demand and consume 40% of all hospital services. Recent experience with community paramedicine pilot programs carried out in 33 communities across Ontario showed a 13.8% reduction in 911 calls and emergency room visits within six months of the program's launch.

Community paramedicine is designed to refocus the health care system on the quality of care it delivers and the best possible use of its resources. It supplements the level of care delivered to patients living with chronic diseases such as diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, and mental health and addiction issues. It uses community health risk screening clinics, in-home care, remote patient monitoring and acute care, including emergency calls, nursing home emergencies and shelters, to reduce unnecessary visits to hospital emergency departments while working under the medical delegation of the patient's primary care physician.

Community paramedicine programs use a tiered chronic-care model, enhancing chronic disease identification, management and hospitalization prevention. This reduces the burden placed on our health care system in terms of both time and resources.

In partnership with the LHINs, health links, community health centres and family health teams, community paramedicine programs could become an integral part of health care services that deter patients from improperly accessing emergency care and assist patients to remain in their homes longer. For this integration to be successful in the long term, it is important that health care providers recognize and value the skills that each provider brings to the interprofessional teams and the continuum of care.

The Ontario Association of Paramedic Chiefs contends that success of the community paramedicine pilots clearly indicates how far paramedicine has advanced and that the next step for paramedics is self-regulation. This would allow paramedics to perform the duties they are trained for as equals to their health care colleagues. It would also allow paramedic services and paramedics to make an even greater contribution to the "patients first" philosophy and to better partner with LHINs, public health and the primary care system.

The Ontario Association of Paramedic Chiefs applauds the Ministry of Health and Long-Term Care for recognizing the need to overhaul the provincial land ambulance dispatch system. We strongly believe that improvements to land ambulance dispatch will enhance community-based care. We ask committee members to encourage the Ministry of Health to continue to work with the Ontario Association of Paramedic Chiefs to introduce a new medical triage system that does not over-triage incoming calls to land ambulance dispatch. In Middlesex-London, for example, 65% of the calls that paramedics respond to are dispatched with the highest priority, yet paramedics only come back from those calls under the same status 19% of the time. That means that 46% of calls are currently over-triaged.

Land ambulance dispatch can also be improved through the implementation of technology to better deploy ambulance resources and by adjusting land ambulance dispatch screening processes to examine opportunities to divert calls to a more suitable resource or a better location for the patient's destination rather than tying up emergency rooms. Deeper integration of land ambulance dispatch and ambulances with other health care providers would better align resources and options to address the patients' needs more appropriately.

One caution we do have for committee members is to not allow the LHIN boundaries and sub-LHIN boundaries, as contemplated by the proposed legislation, to transcend municipal ones. LHIN boundaries should be re-evaluated to reflect the municipally provided services and wherever possible be aligned with geopolitical municipalities. This would strengthen the relationship between service providers and reduce the duplication and gaps in service delivery that currently exist.

We look forward to working with the Ministry of Health and Long-Term Care to ensure strong and effective solutions for strengthening our health care system for communities across Ontario. We strongly believe that paramedics can be a key partner in ensuring that the Patients First strategy is successful.

In summary, paramedic services' ability to contribute will be improved if Bill 41 is amended to designate paramedics as health service providers, making com-

munity paramedicine programs eligible for 100% funding by the provincial government through the LHINs.

We also ask committee members to encourage the Ministry of Health and Long-Term-Care to both establish a college of paramedics and to modernize the land ambulance dispatch system to curtail over-triaging emergency medical calls to 911 and to be used as a conduit to a more coordinated, efficient health care system.

Thank you for the opportunity to appear before you today to inform members about how we believe Bill 41 could be strengthened. We hope you will carefully consider our input, make these important amendments and move quickly to enact the amended legislation.

I would be pleased to answer any questions you may have. Thank you.

The Chair (Mr. Monte McNaughton): Thanks, Mr. Roberts. We'll move to the government and Mr. Dhillon.

Mr. Vic Dhillon: Thank you very much for being here today, and thank you for the important work that you and your colleagues do every day. Our government recognizes the valuable role that paramedics play in our health care system and we're committed to continuing to work together to ensure the highest quality of emergency care for all Ontarians.

In your remarks, you talked about the importance of health systems integration. This is, at its core, what Bill 41 first is about. Can you please elaborate further on why integration is so important in our health care system?

1500

Mr. Neal Roberts: Thank you for the question.

I'm going to refer back to some of the community paramedicine pilots that are currently in place and some of the successes we're seeing. A good example is that often paramedics are viewed as a safety net for the health care system. Prior to some of the community paramedicine pilots, what we were seeing were repeated calls to patients who were not being seen or followed up by a physician or community care access centres. So one of the areas—and I can speak to Middlesex-London—we now have a referral to the CCAC. If we're going out to a patient who has maybe fallen several times, where we've gone two or three times in a week, and the patient is not receiving any care, that patient is now referred to a CCAC for follow-up, and our community paramedicine department will follow up not only with the patient, but also with the CCAC, to ensure that the services are there.

So it's about coordination of the services. It's not about duplication, and it's not about taking over what somebody else is doing; it's about ensuring that the patient's journey through the health care system is uninterrupted but better coordinated.

The Chair (Mr. Monte McNaughton): Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today and for your remarks on the importance that paramedics play in our health care system.

Could you just give us a status on the current community paramedicine programs that are going on? Are they hit-and-miss throughout the province now? Are they coming to a close? Is the funding still available?

Mr. Neal Roberts: Thank you for the question.

Currently, there are 23 pilots. They were extended. The pilots are coming to a conclusion as of March 31, 2017. We have, as an association, been in discussions with the minister and the Ministry of Health with regard to what continues after the pilot period ends. We certainly realize that pilots are only meant for a certain period of time, but we strongly believe that the pilots have proven to be a success, and we would like to see a continuation of those pilots going forward.

The good part about the community paramedicine pilots that have been in place to date is the fact that communities determine the needs. It's not a cookie-cutter or one-size-fits-all; it's based upon community needs and better coordination.

Mr. Jeff Yurek: The start date for this legislation would be April 1, so it would tie in nicely if, in fact, the changes were made to continue the program.

I'm also in agreement with you with regard to municipalities—to ensure that there's coordination with municipalities. Public health, of course, is coming under the LHINs. However, under the LHINs, there are multiple public health units available. I'm sure that the municipalities have different structures needed for paramedicine. I agree that, hopefully, if changes are made, that's taken into consideration.

The Chair (Mr. Monte McNaughton): Madame Gélinas.

M^me^ France Gélinas: I'm pleased to see you. We have been hearing your agency, as well as many paramedics, ask for a self-regulated college for a very long time now. Are we moving forward, or are we still with a minister who doesn't agree?

Mr. Neal Roberts: At this point in time, the recommendation for a college is currently sitting with the minister; it continues to. We do not have clarity with respect to a determination of whether or not to grant a college, or whether or not to accept HPRAC's recommendation to deny the college.

M^me^ France Gélinas: Have you seen HPRAC's recommendations?

Mr. Neal Roberts: I have, ma'am.

M^me^ France Gélinas: What do they recommend?

Mr. Neal Roberts: They recommend the current system, which is the base hospital system that currently is in place, and not to award a college of paramedics.

M^me^ France Gélinas: The designated paramedics as health system providers—that's the first time I've heard of this. My community is one of the ones that have community paramedics. It works beautifully. People love you. It works really well. Are you saying that now that we'll transfer the CCACs to the LHINs, you won't be able to get funded for that anymore?

Mr. Neal Roberts: The concern that we have right now is that your community, as is mine, is a pilot. That funding will terminate as of March 31, 2017. So the 23 programs in the province will cease without any continued funding.

That's what we're seeking through our recommendations today—that there be a more stable funding source. One of the recommendations is either through 100% funding or a designation as a health service provider through the Patients First legislation.

The Chair (Mr. Monte McNaughton): Thank you, Mr. Roberts, for your presentation.

I now call upon the Registered Nurses' Association of Ontario.

Interjection.

The Chair (Mr. Monte McNaughton): We are ahead of schedule. Is the Ontario Chiropractic Association here? No?

We'll recess until 3:15.

The committee recessed from 1505 to 1515.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Monte McNaughton): Okay, we'll get back to public hearings on Bill 41. We have the Registered Nurses' Association of Ontario for their presentation. If you would both state your names for Hansard and then begin with your nine-minute presentation, please.

Ms. Carol Timmings: Thank you so much, Mr. Chair, and good afternoon to you all. My name is Carol Timmings and I'm a registered nurse and the president of the Registered Nurses' Association of Ontario. As the professional association representing registered nurses, nurse practitioners and nursing students in Ontario, we thank you for the opportunity to provide advice regarding Bill 41.

Nursing is the largest regulated health workforce in Ontario, and polls consistently show that we are the most trusted professional group. There are nearly 96,000 RNs, 2,400 NPs and 39,000 RPNs working with Ontarians in all areas of our health system. We are often the eyes and ears for patients and for the health system. Our role is to advance health as well as prevent and treat illnesses. Our everyday experiences working across all sectors and in all roles, from direct care providers to teachers, researchers, policy-makers and top executives, enlighten our understanding of what's working and what must be improved to best serve Ontarians.

This moment in time represents a once-in-a-generation opportunity to deliver on a promise to better our health care system. We are afraid we are wasting a precious opportunity to do what's right for Ontarians.

RNAO assessed Bill 41 with the following in mind:

Will it improve Ontarians' timely access to quality health services where it makes the most sense to receive them? This includes anchoring the system in primary care.

Will it remove barriers so people receive person-centred services that help them as close to home as possible?

Does it promote integration and equally consider structural and service delivery enhancements?

Does it maximize the effectiveness of the system so it's sustainable for generations to come?

While we first cheered Minister Hoskins' bold goals for real and meaningful health system transformation when he released the Patients First discussion paper in December, what we see now falls short in meeting this goal. RNAO's biggest concern is that, left as is, Bill 41 will perpetuate current health system limitations, albeit under a facade. Our written submission provides an overview of RNAO's complete analysis of the bill and 13 recommendations. In our time together, we will focus on key areas.

None of RNAO's feedback should come as a surprise. RNAO has provided detailed advice to the government and opposition parties on how to achieve health system transformation. In fact, RNAO's Enhancing Community Care for Ontarians model, otherwise known as ECCO, first released in 2012, has been extensively quoted by Minister Hoskins and many others as a source of inspiration for what our health system should look like. It is a clear roadmap that details what is needed to achieve whole health system integration, improved access, quality and sustainability.

I want to stress that the government has recognized our model as having informed the development of the bill, but as we have repeatedly pointed out, there are foundational shortcomings in Bill 41 that do not align with RNAO's ECCO model. My colleague Dr. Doris Grinspun, RNAO's CEO, will review these for you.

Dr. Doris Grinspun: Thank you very much for having us today.

First, section 1(3) of the bill seeks to expand the definition of "health service provider" under the LHINs legislation. However, critical players are missing. This includes most primary care providers, public health units and home health care providers. Effective health system integration will not occur unless there is a single body—the LHIN—that is capable of making planning and funding decisions that consider the health system as a whole. Otherwise, we run the risk of perpetuating siloed decision-making that translates into fragmented care for Ontarians. For them, nothing really will change.

The bill does seek to strengthen the role of public health units in supporting planning, funding and service delivery. However, RNAO is concerned that the provisions in the bill are insufficient to adequately advance a population health planning approach in Ontario. For example, sections 9 and 39(1) require the leadership of the LHINs and public health units to "engage" on an ongoing basis. This is a vague and weak expectation with no teeth attached, no clear parameters and no expected outcomes.

For RNAO, public health units must assume a leading role in advancing health equity, as they are the experts in upstream health promotion and disease prevention, as well as analyzing population health needs and delivering community engagement. This sector can no longer remain on the sidelines.

1520

Our first recommendation is to amend section 1(3) of the bill to include all of primary care, public health units,

home health care and support services as health service providers under the LHIN legislation. A number of provisions within Bill 41 position the LHIN as a provider and/or manager of health services. RNAO profoundly disagrees with such a role. As captured in RNAO's ECCO report, the most effective role of the LHINs is to plan, integrate, fund, monitor and be ultimately accountable for local health system performance. It would be ineffective and at times, quite frankly, a direct conflict of interest for LHINs to engage in direct service provision. It is challenging at the best of times, and wrong for most times, to row and steer at the same time. RNAO urges you to not perpetuate the existing limitations of CCACs by having LHINs act as a case management brokerage that allocates hours of service to Ontarians based on a command-and-control approach. Rather, service provision and the management of services should be the focus of health providers that have the best understanding of patient care needs.

Our second recommendation is thus to remove all provisions that would position LHINs as delivering and/or managing health services delivery. Focus the scope of the LHINs only on whole system planning, integration, funding allocation, monitoring and accountability functions. RNAO was the first organization to call for CCACs to be dissolved. Beginning in 2012, in our ECCO report, we argued then and today that maintaining both the CCACs and LHINs results in unnecessary structural duplication. It leads to—by design—fragmented service delivery. It hinders the ability of the LHINs to deliver whole system planning and allocate funding based on demographic and evolving health system needs. RNAO is also concerned, as was Ontario's auditor, with the administrative cost of the CCACs. Having dual agencies—LHINs and CCACs—with their associated costs does not enable the delivery of effective person-centred care.

RNAO is also concerned that Bill 41 simply seeks to transfer the CCACs—including all of their limitations—to the LHINs, in effect creating a merger and business as usual. That's not what nurses had envisioned when we delivered our report in 2012, nor when the minister quoted our report as supporting his own report.

Therefore, our third recommendation is to fully dissolve CCACs and produce true health system transformation by preventing the automatic transfer of all—

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation. We have to move now to Mr. Yurek for questions.

Mr. Jeff Yurek: Continue. I'm listening.

Dr. Doris Grinspun: —by preventing the automatic transfer of all CCAC functions, processes and resources to the LHINs. Instead, efforts must be made to transform the funding models in the community away from fee-for-service and anchor the health system in primary care. This can be done by locating the almost 4,100 CCAC care coordinators within primary care. Respecting collective agreements, a secondment could be struck with the LHINs as the employer—but the CCAC coordinators located now in primary care. Doing so, along with fully utilizing the already existing 4,000 primary care RNs, 1,100 NPs and almost 3,000 RPNs, will enable Ontarians to get the services they need more quickly by securing:

—seamless transitions, so that no Ontarian falls through the cracks when navigating the system;

—an efficient process to initiate home care and support services by primary care or by the hospitals;

—ready access to health information and prompt communication amongst providers;

—reducing duplication of tests and other assessments, thus reducing health expenditures.

In conclusion, RNAO is pleased to contribute its expertise to the review of Bill 41. With the pressing amendments specified in our written submission and our presentation today, the bill could transform Ontario's health system. However, RNAO is gravely concerned that left as is, the bill would do little to put patients first. Nurses are calling for authentic transformation, not smoke-and-mirror approaches.

Thank you very much, and thank you, Chair, for allowing me to end.

Mr. Jeff Yurek: I wanted that in the record. Thanks very much.

The Chair (Mr. Monte McNaughton): And with that, we'll move to Madame Gélinas of the NDP.

M^me^ France Gélinas: Thank you so much for coming and thank you for your presentation. Quickly, because I only have two minutes, the way I see it, the board of the CCAC is gone, the CEO of the CCAC moves in as a VP of the LHIN in charge of community care, and everything else stays the same. Our broken home care system stays the same. Do you see it the same way I do?

Dr. Doris Grinspun: We see it very similarly, France, unfortunately. I don't think all the CEOs of the CCACs will move, but most will. We see that if the LHINs again take the role of service delivery, it will not improve the experience of patients. They will be parachuted, as they are today within CCACs in times of crisis. This will be patients first by crisis, not patients first throughout the continuum of care.

M^me^ France Gélinas: I agree. When the minister says that the Patients First bill comes from your ECCO report, what do you respond to that? ECCO was not about what Bill 41 is, in my point of view. Do you think it was?

Ms. Carol Timmings: France, we believe that many of the principles that were put forward in ECCO were part of the vision, initially, which we were pleased to see. But now, in Bill 41, as both Dr. Grinspun and I have said, we see a concerning departure by what is in the current legislation and what we believe needs to happen, which is whole-system transformation, not incremental.

Dr. Doris Grinspun: So if I can have a second, a reporter friend was asking me today, "So what really happened here?" I actually think that bureaucracy took over. I am extremely sad that the very bold vision of Minister Hoskins is nothing, nothing close, as Carol said, to what is in Bill 41, and it's very sad.

The Chair (Mr. Monte McNaughton): Sorry, we have to move to the government now and Ms. Wong.

Ms. Soo Wong: Welcome back, Carol and Doris. I've two quick questions. I've got two minutes. The first question is, how do we work with your members—I hear that there are two recommendations; I'm going to go through them in more detail—to ensure a smooth transition? Bill 41 will be in some form. I don't know what it will look like. That's the first question in terms of smooth transition.

Second, I'm particularly interested, because you gave us 13 recommendations in your written submission and in your oral presentation, what are your priorities? There's some operation stuff versus structural stuff. You know we've got to do a structural piece, so I want to focus on structure versus the operation piece. So if you can put some priority for us, that would be great.

Dr. Doris Grinspun: First of all, structure is very important. As a nurse-sociologist, I would strengthen that even more. However, structure without changes in service delivery will do nothing for patients.

So if you want priorities, anchor the system in primary care. I think the way it is now, it will be anchored in hospital care again. You want priorities? Yes, the care coordinators need to be employed by the LHINs to prevent changes in their labour agreements, but located physically in primary care where they will know patients from beginning to end.

If you want improvements in population health, and my colleague is an expert in population health, you've got to bring public health units much closer, and this bill is not doing that.

Those are some of the critical recommendations to change what people experience in the system, Soo.

Ms. Soo Wong: Do I have more time?

The Chair (Mr. Monte McNaughton): Twenty seconds.

Ms. Soo Wong: Twenty seconds. Okay. So how do we work with your members, the RNAO, which is the largest sector in health care, for a smooth transition?

Ms. Carol Timmings: I believe our members, Soo, have been really quite vocal through action alerts and certainly making the—

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time. Thanks for your presentation.

Dr. Doris Grinspun: Thank you.

Ms. Carol Timmings: Thank you.

1530

ONTARIO CHIROPRACTIC ASSOCIATION

The Chair (Mr. Monte McNaughton): I now call the Ontario Chiropractic Association. Good afternoon, Doctor.

Dr. Bob Haig: Good afternoon.

The Chair (Mr. Monte McNaughton): You'll have nine minutes for your presentation. If you'd begin by stating your name for Hansard, please.

Dr. Bob Haig: Good afternoon, and thank you very much for this opportunity. My name is Dr. Bob Haig. I'm the CEO of the Ontario Chiropractic Association. With me is Valerie Carter, who's the director of government and external affairs, and Marg Harrington, who's the manager of health policy at the association.

We're recommending two minor amendments to Bill 41 to remove barriers and enhance patient-focused integrated care for low back pain and other musculoskeletal conditions. The amendments would enable LHINs and other agencies to properly utilize chiropractors.

One in five Canadians suffers from chronic non-cancer pain, with back pain as a leading condition.

Three of the top four causes of disability in North America are musculoskeletal, including back pain and neck pain.

Evidence points to back pain as a leading reason for opioid prescriptions. A recent study in the States found that 50% of people with prescribed opioids had back pain.

Currently, the 2016 Centers for Disease Control and Prevention's guidelines on prescribing opioids for chronic pain says that the use of non-pharmaceutical therapies is preferred.

With the opioid situation in Canada being described as a crisis, the importance of non- pharmaceutical therapies is highlighted by the fact that the Canadian Chiropractic Association was invited to the national opioid summit this past weekend and is a signatory to the joint statement of action.

There are currently two ministry pilots aimed at improving care for low back pain in Ontario: the Interprofessional Spine Assessment and Education Clinic, known as ISAEC, and seven Primary Care Low Back Pain pilots. Both of these integrate chiropractors into key roles.

The ISAEC pilots have demonstrated that engaging chiropractors and advanced-practice physiotherapists in assessment and education of low-back-pain patients decreases unnecessary diagnostic imaging and reduces unnecessary specialist referrals and obviously the costs that are associated with all of those.

The Primary Care Low Back Pain pilot integrates chiropractors and other practitioners into interdisciplinary primary care settings and it provides a comprehensive assessment and treatment model. In addition to back pain, in these primary care settings in the pilots the patients typically suffer from significant comorbidities, including other MSK conditions, diabetes and other chronic illnesses, and mental health and addictions issues. Many of these patients have the same characteristics as the highest-cost users within the health care system.

In these Primary Care Low Back Pain pilots that are embedded in primary care, in addition to the reduction in specialist referrals, in addition to the reduction in unnecessary diagnostic imaging, there are also indications of reduced use and prescription of opioids.

Our two minor suggested amendments to Bill 41 and the acts amended by it reflect the key principles of elim-

inating barriers, building evidence-informed solutions, and developing interprofessional-care pathways across the health care continuum.

Currently, patient access to optimal care is limited by the eligibility requirements for ministry or LHIN funding. This barrier prevents patients from accessing health professionals who may be the most qualified. This is because eligibility for funding is limited to specific professions as opposed to being determined by patient need, practitioner competence and the best use of health human resources.

Under the Home Care and Community Services Act, unlike services delivered by physiotherapists, occupational therapists, social workers and nurses, services delivered by chiropractors are not listed as "professional services." That means that an approved agency, such as a CCAC (or a LHIN, following a transfer order under Bill 41) is not authorized to purchase chiropractic services, and therefore patients cannot access them as they could, for example, physiotherapy services.

It means that although chiropractors are front and centre in the current pilots that are running, and even though chiropractors are on the list of professions eligible to be hired in family health teams, community health centres, aboriginal health access centres and nurse-practitioner-led clinics, they don't qualify for funding under the Home Care and Community Services Act. We know that technically this can all be changed by regulation, but we also know that those regulations haven't been touched since 1999. We see this as an opportunity for this to be improved.

Given the success of the ministry's current low-back-pain pilots and the thrust of the provincial low-back-pain, chronic pain, and opioid strategies, we believe there's a significant gap in the provision of appropriate care for Ontarians. So we're recommending that Bill 41 include an amendment to the Home Care and Community Services Act, 1994, to include chiropractic services under "professional services" in section 2(7).

With respect to the Local Health System Integration Act, historical funding arrangements mean that chiropractic clinics are not defined as "health service providers." This also creates barriers and inconsistencies in patient access to appropriate care.

Section 1(3) of Bill 41 repeals paragraph 11 of subsection 2(2) in the definition of "health service provider" and substitutes paragraph 11 by adding several new entities, one of them being, "A person or entity that provides physiotherapy services in a clinic setting that is not otherwise a health service provider." We know that the rationale for this is, essentially, housekeeping so that it would allow current funding arrangements to continue, but we also believe it limits the ability to implement new and innovative models in the future.

Our recommendation is that section 1(3) of Bill 41, which amends paragraph 11 of subsection 2(2) of the Local Health System Integration Act, be amended to include "musculoskeletal care" or "musculoskeletal services" so that clause 16 would read: "A person or entity that provides musculoskeletal services in a clinic setting, including physiotherapy services and chiropractic services, that is not otherwise a health service provider." This would provide for the continuation of existing programs, but it would also provide for the implementation of future innovative and collaborative interprofessional models.

The early successes of both ISAEC and the primary care pilots are demonstrating that new models of care which integrate clinicians based on professional competencies and expertise, including chiropractors, provide significant benefits. Chiropractors have a leading role in all of those models. While we support the principles of the Patients First action plan, we believe that the current wording of Bill 41 creates a barrier and inequity because patients cannot access chiropractic services directly funded by LHINs and other agencies.

We believe that our two suggested amendments would help rectify that, and we would look forward to your support on that. We appreciate the opportunity to talk and to comment—and that's eight minutes.

The Chair (Mr. Monte McNaughton): You did really well. The committee members thank you.

We'll move to Madame Gélinas.

M^me^ France Gélinas: Always a pleasure to see you. Thank you for coming.

Actually, I just read the Primary Care Low Back Pain Pilot summary report last night. It was phenomenal. I was like, "This is very, very successful, and hopefully to be repeated."

What you're telling us is that, to be able to move forward once Bill 41 is going to become law—if and when—we will need to make those two changes in order for even those types of practices to continue.

Dr. Bob Haig: No, I think that those would be able to continue regardless, but there are inequities based on the way things have developed historically over the years. An awful lot of services are provided in those interdisciplinary care settings, and they could be implemented there. But, for example, unless there's the ability to incorporate community chiropractors in care plans, then doing that for those physician groups that are currently not family health teams would not work.

M^me^ France Gélinas: Would not work. Okay.

Dr. Bob Haig: It really is about providing LHINs and other agencies with the ability to evolve and provide programs that make sense to them. There's no expectation that this is going to magically change anything; it's just going to remove barriers. Sometimes they are absolute, strict, legal barriers, and sometimes they're barriers of interpretation.

M^me^ France Gélinas: How many of your members participated in the Primary Care Low Back Pain Pilot, would you know? I'm just curious.

Ms. Valerie Carter: Fifteen. There are fifteen chiropractors in the pilots. Just also to the equity issue, we want to be clear that, if—

The Chair (Mr. Monte McNaughton): Thank you very much. We have to move to the government now: Mr. Fraser.

Mr. John Fraser: Do you want to finish your answer on the pilot?

Ms. Valerie Carter: Just on the equity issue: From the standpoint of the change that we're looking for, within the context of the team-based care models, it would be a non-issue, but if a FHG or a FHO wanted to get access to interprofessional care models, currently the way the governance structures work with those team-based care models, they wouldn't have access. So it's an equity issue. Thanks, John.

Mr. John Fraser: Thank you very much for being here and for your presentation and for all the work. I won't go back into the back pain pilots, but I have had a chance to discuss those with you and I know the success of those. You know that I'm working with SCOPE and one of the challenges is, how do you get the mix to change to make sure people get appropriate care and build value in the system?

We've had a series of different providers here today. Everybody has a different view. I accept your view and I think what you're bringing forward is important for patients and for your profession.

Bill 41 is about strengthening local decision-making. That's health care by evolution, not by revolution. We're not trying to turn everything upside down, on its head. One of the things is that it's a system with people, and as we move forward in a deliberate way, it's staffed by people and it cares for people. I wanted to say that because this is sort of the end. You're the last delegation and I very much appreciate that you came here and what you brought to us, which is to say, "Look, here's how we think we can help."

Dr. Bob Haig: May I?

Mr. John Fraser: Yes.

Dr. Bob Haig: I've been sitting in this room at different times since about 1985; okay? So I understand that it's an evolution. I also know that changing health care models and practices—

The Chair (Mr. Monte McNaughton): Sorry; the two minutes is up.

Dr. Bob Haig: Oh, man, I had a great answer.

The Chair (Mr. Monte McNaughton): We have to move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. You can probably get back to that after my question. This bill is supposed to be about people in creating the systems, and I believe your first amendment removes the barrier so the local LHINs can make up their mind if they want to fund clinics. Is that basically—

Dr. Bob Haig: Basically, that's it. It's getting rid of a current historical barrier that's there, so that decisions can be made on the basis of what's best for the patient and what's best for that local system as opposed to, by definition, it has to be this profession or this profession or this profession. The concept of competency-based rather than profession-based decision-making is one of those things that is evolving faster than legislation. This is an opportunity to help address it.

Mr. Jeff Yurek: And this is nothing outside the scope of practice. This is what chiropractors have been doing since forever.

Ms. Valerie Carter: No, nothing outside the scope.

Mr. Jeff Yurek: This is just removing a barrier that's preventing patients from getting another avenue of care that they need, especially with our—

Ms. Valerie Carter: And specifically for home care, just adding chiropractors to the list, because a lot of patients are seeing the chiropractor in primary care and then when they actually have an incident and they're taking home care, they lose ability to have those services. It's a cleanup more than anything else for that home care legislation.

Mr. Jeff Yurek: Sometimes evolution just isn't fast enough.

The Chair (Mr. Monte McNaughton): Is that it? Great. Thanks for your presentation.

Dr. Bob Haig: Thank you.

The Chair (Mr. Monte McNaughton): I'd like to thank the entire committee for good work on the public hearings. A reminder that the amendment deadline is Monday at 5 o'clock. We'll adjourn until 1 p.m. on Wednesday, November 30.

The committee adjourned at 1544.

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